Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Miles S. Ford JANDARY 09:20 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death BALTIMORE None 46NES Social Security Numbe Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** If Unde 8. Date of Birth Months 1 XM 2 🗆 F 11-6-1968 43 MD 216 78 8301 **Director** Usual Residence of Decedent 28a-f shov 10a. State 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits notified at Director 1 🗆 Yes 2 🖹 No Ellicott City MD Howard 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? ms 23a or Funeral 8629 Frederick Rd United States 21043 items Page 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or iten ledical Examiner r 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Black, White, etc. ş 1X Never Married 2 Married Yes 2 XNo Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: 3 Widowed 4 Divorced Specify: Completed White the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Seconday (0-12) and Mental Hygiene. College (1-4 or 5+ Appliance Repair Retail of Health and Mental Hygie if item 27 is marked other r other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Miles S. Ford Joan C. Heagy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8642 Frederick Rd Ellicott City, MD 21043 Barrington Sweeney/Brother 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ot cemetery, crematory or other place) St. Johns Cemetery 1 X Burial 2 Cremation 3 Removal from State 1-28-2012 Ellicott City, MD 4 Donation 5 Other (Specify) permit. . Signa we of Funeral Service Lie 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. Juanita R Homas 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final and Death Physician STAGE RENAL disease or condition END EHRS Medical resulting in death) Examiner OPONARY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 Yes 2 No 5 Other (specify) Pregnant at time of death Month Day Year 4 ☐ Pregnant g ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perforn 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မှ 1 Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Mann Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Hospital or Attending **Natural** injury 5 Pending Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check

7

State Registrar only one)

JAN 2

6

CATON AVENUE, BALTIMORE

o completed cause of death (Item 23a) (Type, Print)

900

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month Day 15 Physician/ Trula Lizzie Greenwood 2012 6:30 AM January Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Carroll 4605 Brookview Drive Hampstead 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours 230-28-9992 **Director** 1 □ M 2 😾 F 11/2/1922 VA Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director Hampstead Carroll MD 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 21074 USA 4518 Maple Grove Road death \ 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No Examiner Black, White, etc. 9 þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify: white "natural", 3 X Widowed 4 ☐ Divorced Completed the Medical 15. Decedent's Education 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) 1 and 2 should be filed within 72 of Health and Mental Hygiene. Item 27 is marked other than ' Elementary/Secondary (0-12) College (1-4 or 5+) Westinghouse 10 assembly worker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Laura Hale Rendew M. Boyd 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4605 Brookview Drive, Hampstead, MD 21074 Margaret A. Shipley, daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition Date permit. Page 1 a Department of H Important: If ite 1 Burial 2 Cremation 3 Removal from State 1/20/2012 Finksburg, MD injury (Evergreen Memorial 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Eline Funeral Home M00741 any 934 S. Main St., Hampstead, MD 21074 omne Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between 23a. Part shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician/ metastatic disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to for as a consequence of, Exami Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): burialphysician Physician/Medical that the death certificate be Box 68760 the use as attending p IF FEMALE yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Year 5 Other (specify) Pregnant at time of death P.O. I been signed by Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Knowh 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, Completed Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy performed? 1 Yes 2 No has death?
1 Yes 2 No certificate Hospital or Attending Physician: 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Nother (Specify Daughter's ER/Outpatient 3 DOA မ 1 Inpatient 2 I after death.

Director: After this hesidence the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 ☐ Yes 2 ☐ No Natural 5 Pending ☐ Accident ☐ Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide determined within 24 hours a

To the Funeral C

completely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie ျ m.O. WJL 5 Rd. Ste#204 Westminster Md. 21157 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) m. D. Howard 826 Washington

Registrar

31. Date filed (Month, Day, Year)

32. Regirtrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Raymond Sylvester Glover, 201 January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Lutherville/Timonium Baltimore Stella Maris Hospice 9. Birthplace (State or Foreign Country) Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Days Min 212-07-8384 93 **Director** 10/19/1918 XXM 2 \B MD Usual Residence of Decedent 28a-f show at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director the Medical Examiner must be notified Pikesville 1 Yes 2 X No Baltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 21208 USA 601 Upland Road 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces?

1 X Yes 2 No Black White etc ō ģ 1 Never Married 2 Married Maryland 21215-0036 should be filed within 72 hours afte and Mental Hygiene. is marked other than "natural", If Yes, Give Year or Dates.WWII white 1 ☐ Yes 2 🔀 No Specify: 3x Widowed 4 ☐ Divorced Completed Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) liquor distributor displayman liquor sales any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Raymond S. Glover, Sr. Nell Gill 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2540 Coon Clubro Westminster, MD 21157 permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is Raymond P. Glover, son Baltimore, ANUARY 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Lake View Memorial Park 1/19/2012 Sykesville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Signature of Funeral Service Licensee Eline Funeral Home M00741 934 S. Main St., Hampstead, MD 21074 Semmer 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition CONGESTIVE HEART FAILURE Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. First Industrying Cause (Disease or injury Due to (or as a consequence of): Exam burial-trar that initiated events Due to (or as a consequence of): resulting in death) Last physician Physician/Medical law requires that the death certificate be Division of Vital Records, P.O. Box 68760 GLOVER IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown RAYMOND þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 Unknown certificate has been si irector, page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Tes 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred Hospital or Attending 1 X Natural 5 Pending 1 Yes 2 No Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and titl 29d. Date signed (Month, Day, Year) 29c. License number ည WIL 2+IVA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2300 DULANEY VALLEY RD. JONES, CRNP TIMONIUM, MD 21093 JACKIE Redistrar's Signature State JAN 1 8 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Mary Ellen Halbig Physician/ 2012 January 12:25 AM Medical a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Deatl 4c. County of Death **Examiner** Fairfield Nursing Home Crownsville Anne Arundel 8. Date of Birth (Month, Day, Ye Social Security Number 213-22-1002 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. g. Birthplace (State or Foreign **Funeral** Months Hours Oct. 4, Maryland **Director** 1 - M 2XXF 84 Yrs Usual Residence of Decedent 28a-f show Crownsville 10d. Inside City Limits 10b. County 10c. City, Town or Location ms 23a or 28a-f sho must be notified at 10a. State Director Cronwsville Maryland Anne Arundel 1 Yes 2 X No 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number Funeral 21032 619 Evergreen Road U.S.A. items within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status the Medical Examiner Armed Force Black, White, etc ö 1 Never Married 2 Married Yes 2 X No ģ Maryland 21215-0036 White 1 Yes 2 No Specify. If Yes, Give Specify: 'natural", Completed 3℃Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other than Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Homemaker event, Be 17. Father's Name (First, Middle, Last) Harry B. Stubbs 18. Mother's Name (First, Middle, Maiden Surname)
Gladys Hantske and Mental I ၉ t. Page 1 and 2 should be from the truent of Health and Mentartant: If item 27 is marked jury or other traumatic en pe 19a. Informant's Name/Relationship (Type, Print)
Carl E. Halbig, Jr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 112 Margaret Drive Stevensville, Maryland 21666 altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1XXBurial 2 Cremation 3 Removal from State injury or Department of Important: If any injury or once. MD Veterans Cemetery 1/30/2012 Crownsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician/ disease or condition Medical resulting in death) uence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of). and burial-trar resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical The law requires that the death certificate be P.O. Box 68760 use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 to 1 Yes 2 for months? Pregnant at time of death 5 Other (specify) igned by the at be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown Division of Vital Records, 1 Yes plnods peen: 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No page 2 hours after death. 1 Yes 2 No To the Hospital or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be 2 No 1 Pyes 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred iniury 1 Natural 5 Pending 1 Yes 2 No Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide determined within 24 hours a

To the Funeral C

completely filled Medical 🕍 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 only one) 29c. License number 29d. Date signed (Month, Day, Year) 5 of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2 Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Elizabeth G. Hilliard Day 2 2012 January Physician/ 10:30 A M Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Ginger Cove Health Center Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign . Age (In yrs. last birthday) **Funeral** (Month, Day, Y 178-12-3034 93 1918 Pennsylvania 1 M M XX **Director** Usual Residence of Decedent show 10d. Inside City Limits 10b. County 10c. City. Town or Location with the Maryland State items 23a or 28a-f sho ler must be notified at Director Maryland Anne Arundel Annapolis 1 Yes 2 X No 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21409 1828 St. Margarets Road Funeral 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Examiner Armed Forces?
1 ☐ Yes 2 🛣 No Black, White, etc. ō þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 Yes 2 No Specify Yes Give "natural", Completed 3€XWidowed 4 □ Divorced Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry f Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Homemaker the Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, Joseph Guzowski Pearl Zamecki Department of Health and Ment Important: If item 27 is marker any injury or other traumatic e Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print)
Dale Hilliard/son 1828 St. Margarets Road Annapolis, Maryland 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Page 1 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State MD Veterans Cemetery | 1/27/2012 Crownsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility John M. Taylor Funeral Home 21. Signature of Funeral Service Licenses Myelin What 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Dementia Physiciani disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Cerebrovascular Accident Sequentially list conditions. Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Exami Hypertension and use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last attending physiciar Physician/Medical certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) Month in the past 12 months?
1 ☐ Yes 2 🔀 No Pregnant at time of death 1 L Yes 2 2 9 Unknown g 🗌 Unknown the P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, Completed 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of death? page 2 1 Yes 2 XNo 1 Yes 2 No this certificate al or Attending Physician: The safter death.

I Director: After this certifical 26. Place of Death (Check only one) funeral director, 25. Was case referred to medical Be Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 🗌 Yes 2 X No ٩ 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Medical Certificate: 27. Manner of Death injury 1 Natural 5 Pending Investigation
6 Could not be determined Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29d. Date signed (Month, Day, Year) (1-23-2)29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Njideka Udochi, MD

JAN 2 4 2012

31. Date filed (Month, Day, Year)

DHMH 17 Rev 06-2011

Registrar's Signature

9055 Chevrolet Drive Ellicott City, MD

21042

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Vear Month 1/21/2012 Physician/ Mary Catherine Harris 1:35 PM . Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George Mitchellville Collington Nursing Home 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, Birthplace (State or Foreign Country) **Funeral** Min. Hours Months 192-10-1150 1 🗆 M 🕱 🛭 F 92 Director 7/28/1919 PA Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits 10a. State 10c. City, Town or Location within 72 hours after death with the Maryland Director 1 Yes 2XX No Mitchellville Prince George 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ō "natural", or items 23a or idical Examiner must be r Funeral 20721 USA 10450 Lottsford Rd. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Armed Forces?

1 Yes 2 XXo Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White If Yes, Give Year or Dates 1 Yes XX No Specify: Specify: ₩XWidowed 4 □ Divorced Completed Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the AA County Education Bookkeeper 12 and Mental Hygie is marked other Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Esther Marie Harbison permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic once. Elmer Edward Kober 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard Franke Son Harwood, MD 20776 4420 Cobalt Dr. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 XXBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hillcrest Memorial 1/26/2012 Annapolis, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hardesty Funeral Home, P.A. Annapolis, MD 21401 12 Ridgely Ave. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between nset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) Examiner andivarion desease if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner you lem son the Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-trans Due to or as a consequence of) resulting in death) Last physician s the burial Physician/Medical Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ ed by the atten detached for u in the past 12 months? Month Dav Pregnant at time of death 9 Unknown Division of Vital Records, P.O. been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has I completely filled in by the funeral director, page 2 s autopsy performed? Yes 2 No 26. Place of Death (Check only one) Be 25. Was case referred to medical Other: 2 No W Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at work? 1 □ Yes 2 □ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

10 le

29b. Signature and title of certifi

State Registrar naloup 2. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MUS-

29c. License number 20042049 29d. Date signed (Month, Day, Year,

20

anvary

2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Lois Virginia Harris 01/16/2012 7:25 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 505 High Acre Dr., Terr. 31 Westminster Carroll Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** (Month Day Year Days Hours 213-26-4488 Director 1 □ M 2 🔀 F 82 11/07/1929 MD 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director must be notified MD Carroll Westminster 28a-f XX Yes 2 No 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? Funeral 23a 505 High Acre Dr., Terr. 31 21157 USA Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Examiner Armed Forces?

1 Yes No
If Yes, Give Black, White, etc. "natural", or 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 Yes 2 XNo 3X Widowed 4 □ Divorced Completed White Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) n and Mental Hygiene.
77 is marked other than "r Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Gerald Nelson Garrettson Ida Virginia Baxter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t of Health a Carolyn Cheezum/daughter 4554 Louisville Road, Finksburg, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of H
Important: If ite
any injury or oth 1 🐰 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Lakeview Mem. Gardens 01/20/2012 Sykesville, MD 22. Name and Address of Privitts Funeral Home and Chapel, P.A. Signature of Funeral Service Licen 16-412 Washington Road, Westminster, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Deset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner manan Libraria Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
24 hours after death.
25 Hours after death.
26 Hours after Death.
27 Interest Director: After this certificate has been signed by the attending physician and attenderal Director. Interest of page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Pregnant at time of death g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 25. Was case referred to medical examiner?

1 \(\sum \) Yes 2 \(\sum \) No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Medical Certificate: 28d. Describe how injury occurred 5 Pending injury Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined A 24 hours the Funeral Dire 29a. Certifier Certifying Physician: To the best of my know eath occurred at the time, date and place, and due to the cause(s) and manner as stated. Mor investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the asis of examination Certifying Nurse Practiti ner: To the best within 2

To the I

complete only one)

WJL 10

29b. Signature and title of

Alexen

Date filed (Month, Day, Year)

(Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Dorothy Ρ. Henss 201 35 Medical Tanuary 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Carroll Westminster Golden Living Center Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth Birthplace (State or Foreign **Funeral** 1 □ M 2 🔀 F Months Days Hours Country) 9/17/1918 Director 212-01-4319 93 MD Usual Residence of Decedent 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location event, the Medical Examiner must be notified at 10d. Inside City Limits Director Westminster Carroll MD 1 X Yes 2 ☐ No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral **USA** 21157 520 Tremont Drive, Apt. 7 and Mental Hygiene. is marked other than "natural", or items death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces Black White etc. 1 Never Married 2 Married ☐ Yes 2X No δ within 72 hours after Maryland 21215-0036 1 Yes 2 No Specify: white If Yes, Give 3 X Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) own home homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) i and 2 should be fi f Health and Mental item 27 is marked Margaret Proctor Irving Phoebus 19a. Informant's Name/Relationship (Type, Print) Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 223 Alymer Ct., Westminster, MD 21157 Donald R. Henss, Sr., son item Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any Injury or ot Date 1 Surial 2 Cremation 3 Removal from State cemetery, crematory or other place) 1/17/2012 4 ☐ Donation 5 ☐ Other (Specify) Hampstead Cemetery Hampstead, MD 21. Signature of Funeral Service Lice 22. Name and Address of Facility Eline Funeral Home M00741 loude. Semme Main St., Hampstead, MD 21074 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final disease or condition Physician ummi Medical resulting in death) Due to (or as Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine sician and burial-transil Cause (Disease or iinjury that initiated events resulting in death) Last that the death certificate be executed Due to (or as a consequence of) physician Physician/Medical the as attending IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death nse 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown for Month Year page 2 should be detached the P.O. þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, or Attending Physician: The law requires 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed death? Yes 2 1 ☐ Yes 2 ☐ No the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes ပ 2 X No 1 🗌 Inpatient 2 🗍 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred **Natural** work? 1 ☐ Yes 2 ☐ No 5 Pending 24 hours after death Funeral Director: A Investigation 6 Could not be Accident Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) the Hospital Medical 1 A Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hou To the Funer completed fil 29a, Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signatur nd title of certifi WJL completed cause of death (Item 23a) (Type, Print) Rd. Westminster MD 31. Date filed (Month, Day, Year, 32. Registrar's Signature State Registrar JAN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

for State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 7:21 PM Harper Ann January 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** University of Maryland Medical Battimore Center 9. Birthplace (State or Foreign Year If Under 24 Hrs. If Under 1 8. Date of Birth **Funeral** Min **Director** 246 90 3403 1 M 2 XF 58 7/6/1953 NC Usual Residence of Decedent show 10d. Inside City Limits 10a. State 10c. City, Town or Location the Maryland at Director notified 28a-f 1x Yes 2 No DC Washington 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? must be r Funeral 6323 Luzon Ave.NW Apt. 20011 USA items ? 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, ural", or iten I Examiner r Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1 X Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examin Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes Give Specify: Black Completed 3 Divorced 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Mail Clerk Postal Service Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ည Charlie Harper Sr. Ina Mae Swinson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pauline Wooten/Sister 101 S.Joyner St.LaGrange, NC 28551 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place 4 ☐ Donation 5 ☐ Other (Specify) LaGrange Cemetery 1/29/2012 LaGrange, NC 21. Signature of Funeral Service Licensee

Signature of Funeral Service Licensee 22. Name and Address of FacilitLa Grange Funeral Services 111 W.Railroad St.LaGrange, NC 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician Gastrointestinal disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Liver Stage Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Exami attending physician and for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Dav Year Pregnant at time of death ate has been signed by the a page 2 should be detached g 🗷 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Renal Failure 1 Yes 2 No 3 Probably 4 Munknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy this certificate 2 No 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director, After this certific completely filled in by the funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ဂ္ 1 🗌 Yes 2 X No 1 ★ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 5 Pending injury X Natural Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 17/0286935 Januam 24,2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Par Windsen 22 South Baltimore, MD Greene St 21201 31. Date filed (Month, Day, Year) Registrar's Signatur JAN 26

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 24Sally A. Harris $a^{\,\scriptscriptstyle M}$ January 6:30 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 10033 Waterford Drive Ellicott City Howard Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Min Hours Director 577-44-2565 80 09/24/1931 Hawaii Usual Residence of Decedent show 10a. State 10c. City, Town or Location 10d. Inside City Limits with the Maryland notified at Director MD 28a-f Montgomery Silver Spring 1 🗌 Yes 2 🙀 No 10e Street and Number 10f. Zip Code ō 10g. Citizen of What Country? ms 23a or must be r Funeral 9000 Saffron Lane 20901 United States death items Was Deceus.
Armed Forces?
Vas 2 X No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 2 Was Decedent Ever in U.S. 14. Race - American Indian Examiner Black, White, etc. 0 þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: Specify: "natural" Completed 3 Widowed 4X Divorced White Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the 4 Dept. of Defense Art Specialist Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, it Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Henry Bruton Lucy Osborne 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alison Routt - Daughter 10033 Waterford Drive Ellicott City, MD 21042 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Ardent Crematory 01/25/2012 Hanover, MD 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Cancer of endometrium, papillary serous 3 months disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury that initiated events or Attending Physician: The law requires that the death certificate be executed the burial-transi resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of the IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ for in the past 12 months? Pregnant at time of death Month Day Year the a been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed this certificate 2 🗌 No Yes 2X 1 Yes 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Daughters 2 1 Tes 2 **X** No 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Residence 24 hours after death. Funeral Director: After (Month, Day, Year) 1X Natural 5 Pending work?
1 Yes 2 No __ Accident by the Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined filled in the Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) J. Shapur m hleena D35336 January 24, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 15 Deena J. Shapiro, MD 10810 Connecticut Avenue Kensington, MD 20895

DHMH 17 Rev 06-2011

State

Registrar

31. Date filed (Month,

5

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1	For State	State of Ma	-	epartment of H C <i>ertificate of D</i>			ene g. No. 2 N	12 03511
	D		Registrar 1. Decedent's Name (First, Middle, Last)	1,		_		Date of Death Nionth		3. Time of Death
	Physicia Medic	al .	1Xober T 4a. Facility Name (if not institution, give st	Kt	NE		1 1 1 D4h	Van.	1920	12 324 P M
	Examin	er	4a. Facility Name (if not institution, give st			Annapol	Location of Death		Anne Anne	Arundel
100	Funeral Director		5. Social Security Number 6. Sex 503-05-4438		(In yrs. last birtho	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 05/20/1		Birthplace (State or Foreign Country) SD
	and show l at	or	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location				10d. Inside City Limits
	Maryla 28a-f otifiec	irect	MD Anne Aru	ndel	Annapo					1 ☐ Yes 2 🖾 No
	ith the	ralD	10e. Street and Number 7101 Bayfront Driv	e Ant 330	6	10f. Zip Code 21403		1	0g. Citizen of W	USA
36	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by F		2. Was Decedent Ev Armed Forces? 1 V Yes 2 N If Yes, Give	er in U.S. Io	13. Was Decedent of Hi If Yes, specify Cubar 1 Yes 2X No		cify Yes or No- Rican, etc.)		- American Indian, k, White, etc. White
21215-0036	hours a	Completed	15. Decedent's Edu		16a. [Decedent's Usual Occupa			16b. Kind of Bu	siness/Industry
215	nin 72 l ne. .han "r e Med	omp	(Specify only highest grad	completed) College (1-4 or 5+	·) //	Give kind of work done dife. DO NOT use retired)	lunng most of works	ng	US Aı	rmv
d 21	ed within Hygiene. other than ent, the N	a l	17. Father's Name (First, Middle, Last)	4	01:	ficer	18. Mother's Name	e (First, Middle, M		
lan	d be filed Aental Hyg irked oth	입	Robert Niles Kane				Charlot	te Ether	idge	
Aan	should be file and Mental F 7 is marked o raumatic eve		19a. Informant's Name/Relationship (Typ		- 1	Mailing Address (Street a				
re, N	and 2 Health tem 2:		Judith Kane Parker 20a. Method of Disposition	daughter	20b. Place of	Disposition (Name of				City or Town, State
mo	Page 1 nent of ant: If i		1 ☐ Burial 2 🌠 Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	Removal from State	1	crematory or other plactic Cremator	y 01/21	/2012		urnie, MD
Baltimore, Maryland	permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra		21. Signature of Funeral Service License CHUMAGO TRO	mbulo	1	22. Name and Addres	y Ave. Ar	mapolis	MD 21	Home P.A. 401
į,			23a. Part 1. Enter the disease, or compl shock, or heart failure. List only one	cations that caused cause on each line.	the death. Do no		7.5	or respiratory arres	st,	Approximate Interval Between Onset and Death
. 11	Medical	V 9	Immediate Cause (Final disease or condition resulting in death)	Due to (or as a	v 6- consequence of	CANC	EK			
	Examiner		Comportally list conditions	200 10 (0. 10 1		,				
	od sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a	achaequense of	<i>i</i> -				
	xecute al-tran	Exar	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	consequence of):		· · · · · · · · · · · · · · · · · · ·		
200	cate be executed physician and s the burial-transit	edical	L.	d						
Box 6876	requires that the death certificat been signed by the attending ph should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant at	2 Fetal death	3 ☐ Ectopic pregnand 5 ☐ Other (specify) _	су		23d. Dat	te of delivery nth Day Year
	t the de by the	Phys	9 Unknown Part II. Other significant conditions con	9 Unknown	ut not requiting in	the underlying cause give	ven in Part I	and Did tol	and the contr	ribute to the cause of death?
ls, P.O.	uires than signed	by	Part II. Other significant conditions col	tributing to death bu	nt not resulting in	The underlying cause give				3 Probably 4 Unknown
of Vital Records,	Physician: The law requires this certificate has been signard director, page 2 should be	Completed					_	24a. Was ar autops	y F	Were autopsy findings available prior to completion of cause of death?
l Re	sician: The law r certificate has b lirector, page 2 s	e Cor	25. Was case referred to medical			26 PI	ace of Death (Chec			1 Yes 2 No
Vita	ysicia is certi direct	To Be	evaminer?	iospital: 1	ent 2 🗆 ER/Out	patient 3 DOA Oth	or:	ome 5 Reside	ence 6 Cothe	er (Specify)
1 of	ter Ter		27. Manner of Death 1 Natural 5 □ Pending	28a. Date of injur (Month, Day,		jury work		28d. Describe ho	w injury occurre	ed J
Division	Attending or death. ector; After by the fune	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined			M 1 □ m, street, factory, office	res 2 □ No			er or Rural Route Number,
Div	ital or ars after al Dire			building, etc.				City or Town		
	To the Hospital or Attendii within 24 hours after death. To the Funeral Director, At completely filled in by the fu	Medical	Check 2 Medical Examin	er: On the basis of ex	ramination and/or	leath occurred at the time investigation, in my opinion redge, death occurred at the	on, death occurred a	t trie tirrie, gate ari	u place, allu uut	e to the cause(s) and manner stated.
	To the within To the comp	2	29b. Signature and title of certifier	7 radiationer to the	201	29c. Licens				d (Month, Day, Year)
0			Chaff &	n		D/.	5870	7	Van-	20, 2012
	3-16	1	30. Name and address of person who co	OB 69	1306	Per matri	is Blu	of age	n Burn	p 2106/
	Sta Registr		31. Date filed (Month Day Year) JAN 2 4 201	2 32. Registra	r's Signature	bare				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Manyland / Department of Health and Mental Hydiene

			State of Maryland / Dep State Registrar/MEND#23a(a/b)perMD, 1/31/12; BWW, McOG/e				Reg. No.	12 03512
F	Physicia	ın/	1. Decedent's Name (First, Middle, Last) William Alois Kolar		-	2. Date of Dea Month January		3. Time of Death 12 1:26 a M
	Medic Examin	al	4a. Facility Name (if not institution, give street and number)	12 1:26 a M				
	LAdillii	i Ci	Holy Cross Hospital			gomery		
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	y Year)	Birthplace (State or Foreign Country)
	Director		215-12-1001 1 ☒ M 2 ☐ F 94 Yrs. Usual Residence of Decedent			June 21	, 1917	MD
	and show	ř	10a. State 10b. County 10c. City, Town or Lo	ocation				10d. Inside City Limits
	Maryl 28a-f otifie	Director	MD Montgomery Silver					1 ☐ Yes 2 🖾 No
	th the	al D	10e. Street and Number	10f. Zip Code			10g. Citizen of V	What Country?
	ath wi	Funeral	9504 East Light Drive 11. Marital Status 12. Was Decedent Ever in U.S. 13.	20903 Was Decedent of His	spanic Origin? (Spe	ecify Yes or No-	USA 14 Baci	e - American Indian,
980	ould be filed within 72 hours after death with the Maryland of Mental Hygiene. marked other than "natural", or items 23a or 28a-f show marked other than "hadical Examiner must be notified at matic event, the Medical Examiner.	þ	1 Never Married 2 Married 1 Yes 2 No	Was Decedent of His If Yes, specify Cubar 1 ☐ Yes 2 🛣 No		Rican, etc.)	Blac	White etc.
2	2 hou "natu edica	plet	(Specify only highest grade completed) (Give	edent's Usual Occupa kind of work done d	ation luning most of work	ing	16b. Kind of Bu	usiness/Industry
12	within 7 giene. ner than t, the M	Completed	Fede:	oo not use retired) ral Crimin Investigat	na1		Govern	ment
9	lled w I Hygi other	Be	17. Father's Name (First, Middle, Last)	LIIVESLIGA	18. Mother's Nam	e (First, Middle, I		
<u>la</u> r	d be f Menta arked atic ev	ပ	Thomas Kolar		Josephi	ne Pers	ain	
, Maryland 21215-0036	permit. Page 1 and 2 should be file Department of Heath and Mental I Important: If item 27 is marked o any injury or other traumatic eve		·	ing Address (Street a 5 Goosened				
Baltimore,	e 1 ar t of He If iten or oth		20a. Method of Disposition 1 → Burial 2 → Cremation 3 → Removal from State 20b. Place of Disposition 20b. Place of Dispos	osition (Name of matory or other place		Date		City or Town, State
ᆵ	t. Pag rtmen rtant: rjury		4 □ Donation 5 □ Other (Specify) Gate of	Heaven Cen		an. 27, 2012		Spring, MD
Ba	perm Depa Impo any ii							Inc. pring, MD 20901
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Immediate Cause (Final Perforated Colon	er the mode of dying (Non trau	g, such as cardiac (natic)	or respiratory arm	est,	Approximate Interval Between Onset and Death
-	Physician Medical		disease or condition resulting in death) Due to (or as a consequence of):	-				
	Examiner		Sequentially list conditions, b. Colon Obstruction					
	D ₹0	nine	if any, leading to immediate Due to (or as a consequence of):					5.5
	ficate be executed g physician and as the burial-transit	edical Examiner	Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of):					
0	be ex sician	call	d					
3760	ificate ig phy as the		IF FEMALE:					
x 68	tendir or use	ian/I	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3	Ectopic pregnancy	y		23d. Dat	te of delivery
P.O. Box	requires that the death certificensigned by the attending should be detached for use a	Physician/N	1 Yes 2 No 9 Unknown Unknown 1 Yes 2 No 9 Unknown	Other (specify)			1010	intin Day real
0.	that the	by Ph	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause giv	en in Part I.	23e. Did to	bacco use contr	ribute to the cause of death?
	uires i en sigr uld be	ed b				1 🗆 ነ	res 2□No	3 🗋 Probably 4 🖾 Unknown
200	aw red as bee 2 sho	Completed				24a. Was a		Were autopsy findings available prior to completion of cause of
Ř	sician: The law occitificate has to lirector, page 2 s	Con					rmed?	death? 1
ta	ysician: is certific director.	Be	25. Was case referred to medical examiner? 1 Ves 2 No Hospital: 1 Inpution: 2 FER/Outpatient.	T- :	ace of Death (Chec			
<u></u>	ding Phys h. After this funeral di	e: 10	27. Manner of Death 28a. Date of injury 28b. Time of	of 28c. Injury	4 □ Nursing Ho at	ome 5 Resid		
ono	ending eath. or: After he fune	ficat	1 ☑ Natural 5 ☐ Pending (Month, Day, Year) injury 2 ☐ Accident Investigation	M 1 🗆	? Yes 2 □ No			
Division of Vital Records,	pital or Attending Physician: The law requires that the death certificate be executed eurs after death. eurs after death. eral Director. After this certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the burial-transf	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office		28f. Location (S City or Tow		er or Rural Route Number,
-	To the Hospital of within 24 hours at To the Funeral D completely filled in	Medical	29a. Certifier (Check conly one) 1 Certifying Physician: To the best of my knowledge, death conly one) 1 Certifying Physician: To the best of my knowledge, death conly one) 2 Medical Examiner: On the basis of examination and/or inversion only one)	stigation, in my opinio	n, death occurred a	t the time, date ar	nd place, and due	e to the cause(s) and manner stated.
	withi com		29b. Signature and title of certifier	29c. License	number		29d. Date signed	d (Month, Day, Year)
	10		Donald Shor Mis		67355		Januar	ry 21, 2012
			30. Name and address of person who completed cause of death (Item 23a) (Type, Daniel Sherk, MD 1500 Forest Gler		ilver Spr	ing MD	20910	
	Sta Registra		31. Date filed (Month, Day, Year) 2. Registrar's Signature		TAGE PAI	THE STID	20310	
			AVIA					

Baltimore, Maryland 21215-0036

Demit. Page 1 and 2 should be filed within 72 hours after death with the land 2 should be filed within 72 hours after death within 72 hours after

			For	State of Ma	ryland				nd Mental H	lygiene	;		
			Registrar 1. Decedent's Name (First, Middle, Las	<i>t</i>)		Cer	tificate of L	Death	2. Date of	Reg. No	201	200	3510
П	Physicia								Month Jan		29 20i	3. Time o	15 am
	Medic Examin		Regina Matilda 4a. Facility Name (if not institution, give The Lions Center				4b. City, Town, or Cumber 1			40	County of Dea	211	
	Funeral Director		5. Social Security Number 212-18-1847 Usual Residence of Decedent	7. Age	(In yrs. Ia. 92	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Min. (Month.	Birth Day, Year) 2-1919	C	rthplace (State ountry) ryland	or Foreign
	land show dat	tor	10a. State 10b. County		_	, Town or Loc						10d. Inside C	
	e Mary r 28a-1 notifie	Director	MD Alleg	eny	Fr	ostbur	-			1 0"	tizen of What C		s 2 XNo
	s 23a o	Funeral I	13600 Upper Georg	es Creek R	bso		10f. Zip Code 21532				·S·A·	ountry?	
9036	e filed within 72 hours after death with the Maryland tal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ev Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates.	er in U.S lo	If	/as Decedent of H Yes, specify Cuba	n, Mexican,	n? (Specify Yes or N Puerto Rican, etc.)		14. Race - Am Black, Whi Specify:		
21215-0036	ithin 72 hou ene. • than "natu he Medica	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12))	(Give k life. DC	ent's Usual Occup ind of work done of NOT use retired) Iemaker	during most o	of working		ind of Business Home	s/Industry	
Baltimore, Maryland 2	should be filed war and Mental Hygin and Mental Hygin is marked other raumatic event, it	ادہ ا	17. Father's Name (First, Middle, Last) Daniel E. Nola	n					's Name (First, Midd C. Trayn			n	
Mary	2 should Ith and N 27 is ma trauma		19a. Informant's Name/Relationship (7) Carmel R. Daniel		ter	100			or Rural Route Num				
ore,	ge 1 and nt of Hea : If item or other		20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □	Removal from State	20b. Pi	lace of Dispos emetery, crem	sition (Name of eatory or other place	ce)	Date	20c. L	ocation - City o	r Town, State	
3altin	permit. Page 1 and 2 should be 1 Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ex once.		4 ☐ Donation 5 ☐ Other (Specification of Specification o		St		nael's Ce Name and Addre		2-01-12 Sowers F Frostbur		stburg, 1 Home.		
	00 5 8 9		23a. Part 1. Enter the disease, or compshock, or heart failure. List only o		he death						21532	Approxima Interval Be	
٥,	Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)		n.v	W/W	9 A.	1 tag	li ser	V		Onset and	
	Examiner	<u>.</u>	Sequentially list conditions,	b. —	00113044	G1100 01).							
	ted d ansit	Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a	consequ	ence of):							
_	ate be executed hysician and the burial-transit	dical Ex	resulting in death) Last	Due to (or as a	consequ	ence of):							
200	ificate k ig phys as the	ledic		d						-1			
Box 687	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No g ☐ Unknown	23c. If yes, outcome o 1 Live Birth 2 4 Pregnant at 9 Unknown	☐ Fetal	I death 3 🗀	Ectopic pregnand Other (specify)	Э		-	23d. Date of d Month	elivery Day	Year
ls, P.O.	uires that th signed by ald be detad	by	Part II. Other significant conditions of	entributing to death bu	t not resu	ulting in the ur	nderlying cause gi	ven in Part I.	-00	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 1 Yes 4 Pr			
Division of Vital Records,	rsician: The law req s certificate has bee director, page 2 shor	Completed							p	as an utopsy erformed?	prior to death?	utopsy findings completion of es 2 No	
ital	ysician; The la is certificate ha director, page	Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:			Oth	er: A	(Check only one)				
n of V	iding Phys th. After this funeral di	cate: To	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of injury (Month, Day,		ER/Outpatien 28b. Time of injury	28c. Injur	y at	sing Home 5 R 28d. Describ			cify)	
Divisio	To the Hospital or Attending Phy within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)							n (Street an Town, State		ural Route Num	ber,
	To the Hospital within 24 hours of To the Funeral Completely filled	Medical	(Check 2 Medical Exami	sician: To the best of m ner: On the basis of ex- se Practitioner: To the	amination	and/or invest	igation, in my opini	on, death occ	urred at the time, da	te and place	e, and due to the	cause(s) and m	an ner stated.
	To th withir Comp	2	29b. Signature and title of certifier				29c. Licens		IU		te signed (Mon		
	11 m		30. Name and address of person who o	completed cause of de	ath (Item	23a) (Type, P	rint)		17 N			201	
	Sta	i A	31. Date filed (Month, Day, Year)	4 5 TO CAC 32. Registrar	Signati	w t	rosthu	urg M	NO di	53	<u></u>		
	Registr		FEB 0 8 2012	32. Registrar	1. 19	Janes						<u> </u>	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 💪 U For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Louise Lichty Sharon Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Allegany Cumberland WMHS-RMC 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign . Social Security Number 7. Age (In vrs. last birthday) **Funeral** Birtner Country)**MD** Sep 26, 1950 219-56-9905 Usual Residence of Decede 1 🗆 M 2 💢 **Director** 61 28a-f show 10a. State 10c. City, Town or Location aţ 10d. Inside City Limits Director must be notified MD Cumberland Allegany 1 XYes 2 No ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 21502 USA 28 Race Street items within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Black, White, etc. 0.10 þ 1 Never Married 2 Married 1 Yes 2 If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: "natural", Specify. Completed 3 XWidowed 4 Divorced white الم than المدر the Medical E 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) and Mental Hygiene. Finan Center PNBe 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ൧ Mary Louise James Samuel M. Shaffer traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code MD 21539 16 Watercliff Street Jamie Lichty Lonaconing son 27 Department of Healt Important: If item 2 any injury or other once. 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 2/2/2012 MD Hillcrest Memorial Park Cumberland ignature Funeral Service 22. Name and Address of Eacility
Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Complications of multiple vetebral fractures disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to for as a consequence of the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be IE FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Box 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death 5 Other (specify) Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy ge Yes 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) **Division of Vital** Be examiner? Yes Hospital Other: 2 No ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending s after death. 10:30 A M 17/12 2 🗆 No 1 Yes FELL DOWN STAINS Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completely filled in by 4 Homicide determined City or Town, State) Homa NACE ST COMBERLEND within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation in my original death occurred. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 009157 ss of person who completed cause of death (Item 23a) (Type, Print) 30. Name and addi 124 W. Third St. Cumberland, MD Snow M.D Date filed (Month, Day, Year) Registrar

12-00906							
Grant Learman							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

rant Learman		State of Maryland / D	Departmen <i>Certificate</i>			Menta	l Hygien	е	201	2 0351
Physicia	an/	Registrar 1. Decedent's Name (First, Middle,Last)	Cortificate	-			2. Date	Re of Death	g. No.	3. Time of Death
ledical Exami	ner	Grant Learman					Mont Janu		Day Year), 2012	2138 hrs
		Facility Name (if not institution, give street and number) 4827 Bonnie View Court	•	4b	4b. City, Town, or Location of Death Ellicott City				4c. County of Death	1
Funeral			n yrs. last birthda	y)	If Under 1 Year	If Under 2	24Hrs. 8. Dat	te of Birth	h(MM/DD/YYYY) 9. Bir	thplace (State or
Director		216-49-1424 1 xm 2 F	15	Yrs.	Months Days	Hours	Min. 11	./23/	/1996 Foreig	gn puntry) N Y
any		Usual Residence of Decedent 10a. State 10b. County 10c	c. Citv. Town or L	ocatio						10d. Inside City Limits
*		MD Howard	Ellic							1 Yes 2 X No
Aaryland 28a-f show 1 at once.	Director	10e. Street and Number			10f. Zip Code			10	g. Citizen of What Cou	ntry?
ith the Maryland 23a or 28a-f sho notified at once		4827 Bonnie View Court		1	21043	3			United St	ates
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: Ulitem 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must he notified at once	ıeral	11. Marital Status 1 X Never Married 2 Married Armed Forces?	er in U.S. 13		Decedent of Hispa s, specify Cuban, N				14. Race - Amer White, etc.	ican Indian, Black,
ter dea	Fu	1 Yes 2 X			res 2 x No			,	Specify: W	hite
ours af	d by	or Dates: 15. Decedent's Education (Specify only highest grade comple	eted) 16a. Dec	edent's	Usual Occupation	n (Give kin		е	16b. Kind of Business/	
n 72 h	olete	Elementary/Secondary (0-12) College (1-4 or 5+)		•	t of working life. D	JO NOT us	e retired)			
5-0036 iled within 72 Hygiene. I other than the Medical	Completed	8 17. Father's Name (First, Middle, Last)		Dis	abled	Mother's I	Name (First M	Middle M	N/A aiden Surname)	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than injury or other traumatic event, the Medical	Be	Timothy R. Learman							panogle	
D 21 should and Me	٩	19a. Informant's Name/Relationship (Type, Print)							per, City or Town, State	
and 2 sho lealth and tem 27 is traumati	-	Timothy Learman - Father 20a. Method of Disposition			Bonnie on (Name of ceme		Court		Licott City 20c. Location - City or	
Baltimore, permit. Pages 1 an Department of Hea important: If iter		1 Burial 2 X Cremation 3 Removal from State	crematory o	or othe	r place)		02/02/2	012	Hanover	MD
altin mit. P partme portar	- 4	4 Donation 5 Other Specify: 217 ignature of Funeral Service Licensee			ematory me and Address o					ily FH Inc.
	4	Juanita R Thomas		411	2 Old Co	lumbi	la Pike	E13	Licott City	, MD 21043
Physician edical		2 Part I. Enter the disease, or complications that caused the failure. List only one cause on each line.						-		Approximate Interval Between Onset and
miner		Immediate Cause (Final disease or condition resulting in death) a. Complication Due to (or as a consequence)		eri	natal ger	mina]	<u> matri</u>	x her	morrhage	Death
		Sequentially list conditions, b								
U DOM	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	ance of):							
ited J ansit	Exa	events resulting in death) Last Due to (or as a consequence d.	ence of):							12
Sox 68760, death certificate be executed to a strending physician and if for use as the burial - transi	Physician/Medical	▼ UNPENDED AMENDED 23a, 2	7,per me	e,g	926 4-24-	-12 s	m			
760, icate be physici the buri	/Mec	IF FEMALE: 23b. Was decedent pregnant in the	of pregnancy			10.00			23d. Date of delivery	,
Sox 6876 leath certificate e attending phy for use as the l	ician	past 12 months? 4 Pregnant at time	2 e of	1	death 3	Ectopic p	regnancy		Month [Day Year
- e + e	hys	1 Yes 2 No 9 Unknown 9 death Unknown								
P.O.	Š	Part II. Other significant conditions contributing to death bu	it not resulting in t	the und	derlying cause give	en in Part I	. 236		pacco use contribute to 2 ✓ No 3 Prot	
	Completed			-			24a	ı. Was aı		topsy findings available
of Vital Records, ng Physician: The law requir ther this certificate has been someral director, page 2 should land	dwc				 		— 1 	autops perform Yes 2	ned? death?	completion of cause of es 2 \text{No}
tal Re	Be	25. Was case referred to medical					neck only one	-		
n of Vital ling Physician: After this certif		examiner? 1 Yes 2 No Hospital: 1 Inpatient					lursing Home		Residence 6 🗸 Other	: Scene
ading of the	<u>:</u>	27. Manner of Death 1 X Natural 5 Pending 28a. Date of Injury (Month, Day, Year)	28b. Time	of Inju		at Work? s 2 No		scribe ho	ow injury occurred	
Division rate of a rate of	ficat	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury	- At home, farm,	street,				ation (St	reet and Number or Ru	ral Route Number, City
DIVI spital or cours afte	Certification:	4 Homicide determined (Specify)					or T	own, Sta	ate)	
Division To the Hospital or Atte within 24 hours after dee To the Fuoeral Directo completely filled in by the	Medical	29a. Certifier (Check only one) Certifying Physician: To the best of my kn one) Medical Examiner: On the basis of examination								
To with	₩.	29b. Signature and title of certifier			29c. License r	number			29d. Date signed (Mod	nth, Day, Year)
		mes 2.			O.C.M.	.E.			February 1, 2012	
3		30. Name and address of person who completed cause of death Ana Rubio MD. Assistant Medical Examine	,	Baltim	ore Street. Ba	altimore	. MD 2122	3		
	ate	31. Date filed (Morph Per Year) 2010 32. Begistrar's S	Signature /				, 1			
Regist	rar	FED U O 2012 Lensur	· B. A	Pari	Ke					

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 [] | 2 for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3, Time of Death Physician/ livis January 20, 2012 12:02 A M ry Ma Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 309 Linden Avenue Mayo Anne Arundel Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth **Funeral** Months Days Hours Min (Month, Day, Year) **Director** 214-40-2574 1 🗆 M 2 🛂 70 3/24/1941 Maryland Usual Residence of Decedent 28a-f show 10a. State with the Maryland ms 23a or 28a-f sho 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland | Anne Arundel Mayo 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 309 Linden Avenue USA 21106 Latin. Page 1 and 2 should be filed within 72 hours after death w Department of Health and Mental Hygiene.
Important: If item 27 is marked one any injury or other. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 X Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12College (1-4 or 5+ Program Coordinator State of Maryland Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Sumame) 2 James Norman Edelen Virgie Catterton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 919 Truro Lane, Crofton, Maryland 21114 Norman P. Clarke/Son 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 20c. Location - City or Town, State cernetery, crematory or other place)
Lakemont Memorial Gardens 01/24/2012 XBurial 2 Cremation 3 Removal from State Davidsonville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Road, Edgewater, MD 21037 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ METASTATIC LUNG CANGER M disease or condition Medical resulting in death) **Examiner** CORONARY ARTERY DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner ADRTIC and Mitral Valve REPLACEMENT attending physician and for use as the burial-transit Due to (or as a consequence of) Physician/Medical **To the Hospital or Attending Physician**: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicia 1034000 Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Month Day Year signed by the at Id be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has l autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be 1 Yes STX No 0 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Medical Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🔁 Natural 5 Pending 1 Yes 2 No 2 Accident Investigation filled in by the Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 29h. Signature and title of certifier 29d. Date signed (Month, Day, Year) D31997 Mun 20 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANDREW GURDON AD 2003 MEDICAL PKNY STE 100 ANNAPOLIS, MD 21401

DHMH 17 Rev 06-2011

State

Registrar

31. Date filed (Month, Day, Year)

JAN 2 3 2012

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - \$\frac{\fir}\f{\f{\frac{\frac{\frac{\frac{\frac{\frac{\frac{\frac{\frac{\f Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 1, 2012 Month Physician/ 0202 M Arthur Jerome Levens anuary Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Brooke Grove Rehabilitation and Nursing Center Spring Montgomery Sondy 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 **X** M 2 □ F Country Wisconsin Months Hours (Month, Day, Year) 09/29/1917 390-14-8063 94 Director Usual Residence of Decedent than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits rector 1 Yes 2 X No Spencerville Maryland Montgomery ā 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral U.S.A. 1018 Parrs Ridge Drive 20868 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) death 12. Was Decedent Ever in 19914 -14. Race - American Indian 11. Marital Status Armed Forces? 1944 XYes 2 \(\subseteq \text{No } \frac{1946}{1946} þ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates White 3 ₩ Widowed 4 □ Divorced 1966 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 7: Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me College (1-4 or 5+) Elementary/Seconday (0-12) Medical Doctor Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Arthur M. Levens Cora M. Finger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1018 Parrs Ridge Drive, Spencerville, Maryland 20868 Luanne K. Levens - Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Ukn 1 🕅 Burial 2 🗆 Cremation 3 🕅 Removal from State Arlington, Virginia 4 ☐ Donation 5 ☐ Other (Specify) Arlington Natl Cem. 5/15/2012 22. Name and Address of Facility Hines-Rinaldi Funeral Home, 21. Signature of Funeral Service Licensee hich 1 1800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Parkinson's disease Physician/ years disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Cause (Disease or iinjury Physician: The law requires that the death certificate be executed and that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ___ in the past 12 months? Month Day Year ☐ Pregnant at time of death☐ Unknown Yes 2 No the Hospital or Attending Physician: The law requires that the dethin 24 hours after death.

the Funeral Director: After this certificate has been signed by the ampleted filled in by the funeral director, page 2 should be detached 9 Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tohacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed. 1 ☐ Yes 2 ☐ No Yes Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? 2**X** No Hospital: မြ 1 Inpatient 2 ER/Outpatient 3 I DOA 4X Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending injury 1 Natural work? 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deam occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) January 21, 2012

Registrar

man, M.D. 18100 Stade School Road Sondy Spring

physician

2. Registrar's Signature

attending

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Grace Brooke Huff Date filed (Month, Day, Year)

25 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 401 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 1544 Рм January Belva Sybile Lee Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Ceci1 E1kton Apple Lane 6. Sex Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Davs Hours Min JAN 127, Year 933 1 M 2 X F Onio 79 268-28-5415 Director Usual Residence of Decedent Fr than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10d. Inside City Limits 10a, State 10c. City. Town or Location filed within 72 hours after death with the Maryland Director 1 Yes 2 X No Ceci1 E1kton Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21921 United States 250 Sycamore Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 No by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: Specify: White 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 h
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "ne any injury or other traumatic event, the Medicone. (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) In Her Own Home Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Mary Drefus Estel Pennington 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Apple Lane, Elkton, MD 21921 Bevy Moon/Daughter 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State February Giffelia commatory or other place) Memorial Park Elkton, MD 3, 2012 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hicks Home for Funerals, P.A. 21. Signature of Funeral Service Licensee 103 W. Stockton Street, Elkton, MD 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ UNG CANCER disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate the attending physician and hed for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? Day 5 Other (specify) 1 ☐ Yes 2 ☐ 9 ☐ Unknown page 2 should be detached been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed?

1 Yes 2 K No this certificate has 25. Was case referred to medical completed filled in by the funeral director, 26. Place of Death (Check only one) Be examiner? Daughter Residence S Hospital Other: 4 Nursing Home 5 Residence 6X Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: To 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred : After t 1 🗖 Natural injury 5 Pending 24 hours after death. Funeral Director: Al 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2. only one 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Dav. Year) MD 12 D0062190 3 M 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHAHNAWAZ ICHAN MD AUGUSTINE HERMAN HWY, SUITEA, CHESAPEALECITY, MD 21915. 31. Date filed (Month, Day, Year) State

Registrar

FEB 08

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 18 2012 Jamuary Lela Morgan 8:45 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 1358 Oak Avenue Anne Arundel Annapolis Social Security Numbe If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Hours Country) 063-24-4198 Director 1 □ M 2**X** F 84 April 4 1927 Georgia Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits ms 23a or 28a-f sho must be notified at Director Maryland Anne Arundel 1 ☐ Yes 2 X No Annapolis 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral 1358 Oak Avenue 21403 USA death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2 No Medical Examiner Black White etc. ö þ 1 Never Married 2 Married altimore, Maryland 21215-0036 filed within 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify. Specify: "natural", **Black** 3 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Il Hygiene. Elementary/Secondary (0-12) 12th College (1-4 or 5+) the 2yrs Secretary Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) nd Mental F marked o ပ Johnnie Dixon Lillie Mae Gardner 19a. Informant's Name/Relationship (Type, Print) and is m 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t of Health a Raymond Morgan (Husband) Annapolis, Md. 21403 1358 Oak Avenue 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Page 1 a cemetery, crematory or other place) Department of Important; If it any injury or o 1 X Burial 2 Cremation 3 Removal from State Lincoln 1 - 27 - 12Brentwood, Md. 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licenses P.A. Winname Reese of &cilitSons Mortuary, 1922 Forest Dr. Annapolis, Md. 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ DEMENTIA Medical resulting in death) Due to (or as a consequence of) **Examiner** Disease Sequentially list conditions, it any Lading to immedicause. Enter Underlying Cause (Disease or injury Due to for as a consequence of Exami burial-trar that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physicis completely filled in by the funeral director, page 2 should be detached for use as the bu P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Month Year Pregnant at time of death 1 Yes 2 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown Division of Vital Records, Cardiovascular disea 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \(\text{Nursing Home} \) 5 \(\begin{array}{c} \text{Residence} \) 6 \(\text{Other} \) Other (Specify) Hospital: 2 🗗 No ဂ္ 1 Yes 1 Inpatient 2 FER/Outpatient 3 I DOA 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Natural injury 5 Pending Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year)

DHMH 17 Rev 06-2011

State Registrar Eunapolio MO

e and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 34120M nu 201 Medical 4a. Facility Name (if not institution, give street and number Examiner 4b. City. Town, or Location of Death BUPNI If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 🛚 M 2 🗆 F **Director** None P.R. China 09/19/1940 71 28a-f show 10a. State 10c, City, Town or Location 10d, Inside City Limits with the Maryland **Funeral Director** Examiner must be notified 1 X Yes 2 No Beijing Chau Yang Dist. Fa Tau o 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a P.R. China Jin Chan Bei Li #21 Building3 2-401 10023 permit. Page 1 and 2 should be filed within 72 hours after death vollepartment of Health and Mental Hygiene. Importanti: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner muonee. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc ģ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Asian Specify: Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Construction Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Bingyi Mu Shanghua Tan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 305 Silo Ridge Ct. Apt.104 Odenton, MD 21113 Xiaochun Mou (daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 01/23/2012 Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory Signature of Funeral Service Ocensee 22. Name and Address of Facility Hardesty Funeral Home Annapolis Rd. Gambrills, MD 21054 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ ON disease or condition Medical resulting in death) r as a consequence of Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last physician Completed by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 use as 1 attending IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy for in the past 12 months? Month Day Year Other (specify) Pregnant at time of death 9 Unknown the detached 9 Unknown by signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? be 1 Yes 2 No 3 Probably 4 Unknown page 2 should been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has I autopsy performed Yes 2 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director, it 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: Yes ဂ္ 2 🗌 No €R/Outpatient 3 ☐ DOA 1 Inpatient 2 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work?
1 \(\subseteq \text{Yes} \) 28d. Describe how injury occurred Natural Accident injury 5 Pending 2 🗆 No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check the only one) 29b. Signature and title of certifier puty 2 29d. Date signed (Month, Day, Year, dause of death (Item 23a) (Type, Print) ONES retica

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Year 01/20/201^{D2} Mammano 9:40 A Judith Α. Medical 4a. Facility Name (if not institution, give street and number) . City, Town, or Location of Death Forestville **Examiner** ^{4c.} County of Death Prince George's 6517 Lacona Street Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Days Hours 578-50-8741 **Director** 1 M 2 X F 73 11/28/1938 Yrs Washington, DC Usual Residence of Deced 28a-f show 10a. State 10b. County aţ 10c. City, Town or Location 10d. Inside City Limits Director Examiner must be notified 1 Yes 2XXNo Maryland | Prince George's Forestville 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 6517 Lacona Street **USA** 20747 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. or, ģ 1 Never Married 2 X Married within 72 hours after Maryland 21215-0036 her than "natural", c t, the Medical Exam If Yes, Give Year or Dates 1 ☐ Yes 2XXNo Specify. Specify: White 3 Widowed 4 Divorced Completed Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 h and Mental Hygiene. Elementary/Secondary (0-12) 12th College (1-4 or 5+) Homemaker In Home other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Arthur Rohan Mary Hall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health ar Important: If item 27 is any injury or other Frank J. Mammano / Husband 6517 Lacona St. Forestville, Maryland Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 XXBurial 2 Cremation 3 Removal from State cemetery, crematory or other place) 01/24/2012 Suitland, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cem. ol Koneral 22. Name and Address of Facility George P. Kalas Funeral Home PA 21. Signatur 6160 Oxon Hill Rd. Oxon Hill, Maryland 20745 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. 23a. Part shoot Interval Between Immediate Cause (Final Onset and Death KIDNEY CANCER Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) executed burial-transi Cause (Disease or injury that initiated events and Due to (or as a consequence of) resulting in death) Last physician s the burial Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Records, P.O. Box 68760 use as nding IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No for Month Day Year Pregnant at time of death ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed d be def by 2xx No 3 ☐ Probably 4 ☐ Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has ; page 2 : autopsy performed? Yes 21 No 1 Yes 2 No Division of Vital certific 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Hospital Other: _2 🛚 No 1 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 XXResidence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After 1 X Natural 5 Pending a Funeral Director: Aff Etely filled in by the ful 1 Yes 2 No Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 🔼 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated completely

State Registrar

within 2 To the I

Manish Agrawal 31. Date filed (Month JAN 2 4 201

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

only one)

3 29b. Signature and title of certifi

> MD 6420 Rockledge Dr. #4200 istrar's Signature

DHMH 17 Rev 06-2011

Medical Examiner: On the basis of examination and/or investigation, In my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

62234

Bethesda, MD

29d. Date signed (Month, Day, Year)

January 23, 2012

20817

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death JANUARY 2012 Physician/ 8:55 P M ROBERT FRANKLIN MANAHAN Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FREDERICK FREDERICK FREDERICK MEMORIAL HOSPITAL Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 7. Age (In vrs. last birthday) **Funeral** Hours 213-40-3257 Director 1 M 2 □ F May 26, 1942 Maryland 69 Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10c. City, Town or Location at 10a. State Director ems 23a or 28a-f sh r must be notified a Emmitsburg 1 Yes 2 No Maryland Frederick 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21727 Funeral 17331 Mountain View Road USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S Examiner Armed Forces?

1 Yes 2 No Black, White, etc 5 1 Never Married 2 Married þ. within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. If Yes, Give Year or Dates Specify: white er than "natural", the Medical Exa 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Construction Carpenter 10 Be filed 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Ruth Bowman Lloyd Manahan traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health at Important: If item 27 is any injury or other trau 17331 Mountain View Road, Emmitsburg, MD 21727 Judy Manahan, wife 20c. Location - City or Town, State 20a. Method of Disposition 20b Place of Disposition (Name of Oaketernaw Place) 1 Burial 2 Cremation 3 Removal from State Gettysburg, PA 01/19/2012 Memorial Cemetery 4 Donation 5 Other (Specify) 22. Name and Address of Facility Myers-Durboraw Funeral Home Signature of Funeral Service Licensee 210 W Main St, Émmitsburg, MD 21727 ter 93a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Strock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death abstructure Physician/ rome disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence or) burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 the use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months? õ Month Year Day 5 Other (specify) Pregnant at time of death been signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy has page 2 performe death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 1 ☐ Yes 2 ☑ No Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) မှ After this funeral 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 Yes 2 No 27 Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: injury 1 Natural 5 Pending after death. the f Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide determined City or Town, State) within 24 hours a

To the Funeral C

completely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Gertifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check To the 29b. Signature and litle of c 29d. Date signed (Month, Day, Year) WJL 5 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Airy MD B

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ DAVID ALFRED MACKIE JANUARY 2012 2:58 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2269 TELEGRAPH ROAD RISING SUN CECIL 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) FAIR HILL MARYLAND 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Months Min. 218-40-7581
Usual Residence of Decedent **Director** 1 🕅 M 2 🗆 F FEB. 20, 1934 77 Yrs. show 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location notified at Director 28a-f 1 Yes 2 X No RISING SUN MARYLAND CECIL ö 10e. Street and Number 10g. Citizen of What Country? ms 23a or must be r Funeral 2269 TELEGRAPH ROAD UNITED STATES 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in LLS. Race - American Indian, Black, White, etc. Armed Forces?

1 Yes 2 No ō þ 1 Never Married 2XXMarried Examil Page 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. Fant: If item 27 is marked other than "natural", or lury or other traumatic event, the Medical Examilury or other traumatic event, the Medical Examil Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🛣 No Specify. Specify: WHITE 3 Divorced 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) SELF-EMPLOYED FARMER AGRICULTURE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) မ HENRY M. MACKIE, SR. BERNICE S. GRAY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PAULINE A. MACKIE / WIFE 2269 TELEGRAPH ROAD, RISING SUN, MARYLAND 21911 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or otl once. JANUÄRY 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place) SHARPS CEMETERY 26, 2012 FAIR HILL, MARYLAND 22. Name and Address of Facility CROUCH FUNERAL HOME, P.A. 127 SOUTH MAIN STREET, NORTH EAST, MARYLAND 21901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ IVER disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last and for use as the burial-tran Due to (or as a consequence of): attending physician Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Fctopic pregnancy in the past 12 months?
1 Yes 2 No Day 5 Other (specify) Month Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an cate has to page 2 s prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy Yes 2 X N 25. Was case referred to medical filled in by the funeral director, 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify, Hospital: 1 🗌 Yes 2 X No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After 5 Pending injury work?
1 Yes 2 No 1X Natural Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined

24 hours after deat Funeral Director: within 24 ho

To the Fune

completely f

15 Registrar

Medical

29a. Certifier

(Check

only one) 29b. Signature and title of ce

> HERMAN HWY, SUITEA, CHESAPEAKE CITY, AUGUSTINE 32. Registrar's Signatur

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

🛂 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

D0062190 SHAHNAWAZ KHAN

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Reg. No. 2 Certificate of Death , Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 11:07 A M Suzandrea Muhlmeister January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Annapolis Anne Arundel Anne Arundel Medical Center If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Year) **Director** 220-70-1514 1 M 2 XF 58 10/19/1953 Maryland Usual Residence of Decede 28a-f shov at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Examiner must be notified Maryland Anne Arundel Annapolis 1 Yes 2 X No 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? items 23a 21401 3016 Arundel on the Bay Rd. United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. ō by Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White "natural", 3 Widowed 4 Divorced Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working should be filed within 72 and Mental Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the Disabled Disabled 0 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Joseph G. Muhlmeister Catherine Lorraine Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, permit. Page 1 and 2 st Department of Health ar Important: If item 27 is any injury or other trans 31 Owensville Road, West River, Maryland 20778 Sharon Latham/Sister 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Hillcrest Memorial Cemetery: 01/24/2012 Annapolis, Maryland 22. Name and Address of Facility George P. Kalas Funeral Home tu f Funeral Servi 21. Signati 2973 Solomons Island Road, Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ urose 10 disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injur that initiated events resulting in death) Last and burial-tra Due to (or as a consequence of): nding physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 the use as IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No jo 5 Other (specify) Month Day Year Pregnant at time of death signed by the a P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an ate has page 2 s autopsy performed certificate 1 Yes 2 No Division of Vital 25. Was case referred to medica 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After iniury 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation within 24 hours after death

To the Funeral Director: / 6 Could not be 3 Suicide 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of 29c. License number 29d, Date signed (Month, Day, Year, 18-2012 1280

State Registrar gistrar's Signature

AAMC

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		_	For State Registrar	Otate of iv	iai yiai iu		tificate of		iu Mentai ny	Reg. No. 2	012	0352
ı	Physicia		Decedent's Name (First, Midd) JOHN LESLIE M						2. Date of De Month 01/19/		Year	3. Time of Death 9:05 A
	Medic Examin		4a. Facility Name (if not institution 7229 Mill Run	n, give street and number)			4b. City, Town, o			4c. Cou	inty of Death	n
	Funeral Director		5. Social Security Number 224-56-9527		ge (In yrs. last	t birthday) Yrs.	If Under 1 Year Months Days	If Under 24	Hrs. 8. Date of Bin (Month, Date 10/29/	th		hplace (State or Foreign
	aryland a-f show ified at	Director	Usual Residence of Decedent 10a. State 10b. County MD Monto	gomery	10c. City,	Town or Loc	ation					10d. Inside City Limits Y Yes 2 N
	with the M 23a or 28 ust be not	Funeral Dir	10e. Street and Number 7229 Mill Run				10f. Zip Code 20855	;		10g. Citizen	of What Cou	
9600	e filed within 72 hours after death with the Maryland that Hygiene. ed other than "natural", or items 23a or 28a-f show ed other, the Medical Examiner must be notified at	þ	11. Marital Status 1 ☐ Never Married 2 ☐ Ma 3 🌠 Widowed 4 ☐ Divorce	d If Yes, Give Year or Dates.	196 199	0 1	Yes 2 XN	o Specify:	? (Specify Yes or No- uerto Rican, etc.)	14. F Spec	Race - Ameri Black, White, cify: Bla	, etc.
21215-0036	ithin 72 ho ene. r than "na: the Medic	Completed		ent's Education lest grade completed) College (1-4 or s	5+)	(Give ki life. DC	ent's Usual Occu ind of work done NOT use retired Armed	during most of			f Business Ir Air Fo	
land 2	should be filed within n and Mental Hygiene. 7 is marked other that raumatic event, the M	To Be	17. Father's Name (First, Middle, Lest Thomas M					18. Mother's	Name (First, Middle,	Maiden Suma		
Baltimore, Maryland	1 and 2 should be fi if Health and Mental item 27 is marked other traumatic ev		19a. Informant's Name/Relations Gerald D. Myr:		11	19b. Mailing	Address (Street Viill Run	and Number o	r Rural Route Number, Derwood,	er, City or Towr MD 20	n, State, Zip 855	Code)
imore			20a. Method of Disposition 1 X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (3 ☐ Removal from State	cen	netery, crem ngton	ition (Name of atory or other pla Nat'l C	em 0.	Date 1/26/2012	Arlin		
Ball	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service	MO15		24	5 N. Was	hington	Snowden H n St, Rock	ville,		0850
	Physi_ian/ ∤ Medical		23a. Part 1. Enter the disease, o shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	only one cause on each line	_{e.} c osbt	ructi	the mode of dying the pulmon			rest,		Approximate Interval Between Onset and Death YTS
-	Examiner	ner	Sequentially list conditions,	Due to (or as Coronal b.	ry art	ery d	isease				-	10 yrs
	ificate be executed g physician and as the burial-transit	ıl Examiner	if any, leading to infinediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last	c. Cardio Due to (or as	myopa	thy					- :	10 yrs
8760	tificate be ng physici as the bu	Medical	IF FEMALE:	d								
. Box 68	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit.	Physician/N	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome 1 Live Birth 4 Pregnant a 9 Unknown	2 Fetal d	leath 3 🗌	Ectopic pregnan Other (specify)	су			Date of delive Month	very Day Year
ds, P.O.	luires that the signed by all the detail	by	Part II. Other significant conditi	ons contributing to death b	out not resulti	ing in the un	derlying cause g	iven in Part I.				the cause of death?
Record	The law require sate has been si page 2 should I	Completed			_				24a. Was auto perfo 1 □ Yes	psy		opsy findings available ompletion of cause of
/ital	sician; certific	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ▼ No	Hospital;	ent 2 🗆 EF	2/0.1.	Ott	ner:	Check only one)			
Division of Vital Records,	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director. After this certificate has completed filled in by the funeral director, page 2:	Certificate: T	27. Manner of Death 1 X Natural 5 ☐ Pendi	28a. Date of injung (Month, Date of Injung)	iry 28 y, Year)	Bb. Time of injury	28c. Injur work M 1	ry at	ng Home 5 X Resi 28d. Describe I			у)
Divis	To the Hospital or Attent within 24 hours after deat To the Funeral Director: completed filled in by the		4 Homicide determ	nined 28e. Place of Injurbuled building, etc	c. (Specify)				City or Tov	vn, State)		al Route Number,
	o the Hos vithin 24 hc o the Fune ompleted 1	Medical	(Check 2 L_ Medical I	g Physician: To the best of Examiner: On the basis of e g Nurse Practioner: To the	xamination ar	nd/or investig	ation, in my opini	on, death occur ne time, date an	red at the time, date a	and place, and	due to the ca manner as s	ause(s) and manner statestated.
0	F = 53		Drynd	Ham	M.	MS	010	01240	0134	OI	24/2	LOIZ
			Name and address of person	who completed cause of d	cam (item 23	oa) (Type, Pri	mJ					

State Registrar

Pacowski, Ingrid 8901 Wisconsin Avenue, Bethesda, MD 20889 31. Date filed (Month, Day Year)

JAN 25 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dominique Alice Marie Francoise MICHELSON Physician/ 3:55 P. M January 21,2012 ea Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Suburban Hospital Montgomery Bethesda Social Security Number 8. Date of Birth 0c/160nth, 23, 9. Birthplace (State or Foreign Country) France **Funeral** 6. Sex last birthday) If Und Months 1 - M 2 X F Min Year 1938 061-38-7451 Yrs. Director Usual Residence of Decedent 10a. State ms 23a or 28a-f sho must be notified at 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director Kensington 1 Yes 2 X No Maryland Montgomery 10e. Street and Number 10g. Citizen of What Country? Funeral 20895 United States 4001 Wexford Drive ural", or items ! I Examiner mus 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ Yes 2 No Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify "natural", Specify: white Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) National Cathedral nt of Health and Mental Hygiene.

L. If item 27 is marked other than or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) istant Facilities Manager School 3 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Cecile Gerardin ပ Jacques Thieck Page 1 and 2 should be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4001 Wexford Drive, Kensington, MD David Michelson, Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Department of Important: If any injury or Metropolitan Crematory 01/24/12 Alexandria, VA 4 ☐ Donation 5 ☐ Other (Specify) Sign live of Fun ral cervice Licensee Torchinskyss Hebrew Funeral Home 008 254 Carroll St., NW, Washington, 20012 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Minutes Physician. Respiratory Distress disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Uncerlying Due to (or as a consequence of): transit Cause (Disease or iinjury and that initiated events Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be estathours after death.
Funeral Director: After this certificate has been signed by the attending physicia Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Year 5 Other (specify) Pregnant at time of death 9 Unknown ed by the a detached t 1 ☐ Yes ∠ ☐ 9 ☐ Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hypertension, Hyperlipidemia 1 Yes 2 No 3 Probably 4 Unknown cate has been sig ; page 2 should b 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 X No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 X No ၉ 1 Inpatient 2 KI ER/Outpatient 3 II DOA 4 Nursing Home 5 Residence 6 Other (Specify) ted filled in by the funeral 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred injury 5 Pending 1 Pes 2 No Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined To the Hospital within 24 hours a To the Funeral C Medical 29a. Certifier 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29c. License number 29d. Date signed (Month, Day, Year)

January 23, 2012 D 63325 ain. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10810 Connecticut Ave., Kensington, MD 20895 Laurie M. Crain, M.D., 31. Date filed (Month, Day, Year)
JAN 25 2012 Registrar's Signa State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deal Physician/ Jan 19,2012 11:30am м Mary Katherine Noel Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Bethesda 9707 Old Georgetown Rd 9. Birthplace (State or Foreign County) Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Days 400-22-4853 1 DM 2 X Hours March 26, 191 Director Usual Residence of Decedent th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director 1 Yes 2 No Bethesda MD Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 20814 9707 Old Georgetown Rd 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. þ ☐ Never Married 2 ☐ Married within 72 hours after Baltimore, Maryland 21215-0036 White 1 Yes 2 No Specify: Specify: 3 Widowed 4 □ Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done of Jife. DO NOT use retired) Homemaker (Specify only highest grade completed) during most of working Elementary/Seconday (0-12) Callege (1-4 or 5+) Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F is marked o ည Mamie Hall Garland Sledge 1 and 2 should be f Health and Me Item 27 is mark 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10404 Strathmore Park Ct., N.Bethesda, MD 20852 19a. Informant's Name/Relationship (Type, Print) Linda Naftalin/Daughter item 20a. Method of Disposition
1 ∰ Burial 2 ☐ Cremation 3 ∰ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o Bowling Green, KY Jan 23,2012 Fairview Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Joseph Gawler's Sons, INC 21. Signature Funeral Service Licensee 5130 Wisconsin Ave, N.W. Washington DC 20016 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Pulmonary Hypertension Pnysician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Chronic Renal Failure Sequentially list conditions Que to for as a consequence of: if any leading to in medicause. Enter Underlying Atrial Fibrillation the Hospital or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death. the Funeral Director: After this certificate has been signed by the attending physician and Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) the attending physician a hed for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Pregnant at time of death signed by the a Id be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2√ No 3 Probably 4 Unknown 1 🗌 Yes icate has been sig Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No death? 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 X No Hospital Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury work?
1 Yes 2 No Natural 5 Pending М Accident Investigation the 3 Suicide 4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) pleted filled in by determined 29a, Certifier Xcertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 h. To the Fr. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 only one 29d. Date signed (Month, Day, Year)
Jan 19,2012 29b. Signature and title of certifie 29c. License numbe D55258

State

Registrar

Gary B.

31. Date filed (Month, Day, Year)

JAN 25 201

32. Registrar's Signature

7758 Wisconsin Ave #211 Bethesda, MD 20814

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Wilks, M.D.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 2012 Physician/ Opal D. Overturf 7:50 a January 15 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll Carroll Hospice Dove House Westminster 8. Date of Birth Apr 16, 1927 9. Birthplace (State or Foreign Social Security Numbe If Under 1 Year If Under 24 Hrs. **Funeral** Days 1 **X** M 2 □ F Months 84 Hours Illinois 356-22-0424 Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b, County 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location Director Westminster 1 Yes 2 No Maryland Carroll 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral 4717 Old Hanover Road 21158 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11 Marital Status Armed Forces?

1 X Yes 2 No
If Yes, Give Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify white 3 Widowed 4 Divorced Completed Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Postal Service Mechanic 10 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Willie Overturf Flora Zella Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4717 Old Hanover Road, Westminster, MD 21158 Sharon Ralston, wife 20b. Place of Disposition (Name of Acameter General Property (Name of Acameter Place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Removal from State 1/17/2012 Manchester, MD 4 ☐ Donation 5 ☐ Other (Specify) Crematory 22. Name and Address of Facility Myers-Durboraw Funeral Home Signature of Funeral Service Licensee 91 Willis Street, Westminster, MD 21157 Part J. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Metastatic Prostate disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-trar that initiated events Due to (or as a consequence of): resulting in death) Last ned by the attending physician Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year for Month Day 5 Other (specify) Pregnant at time of death 2 No cate has been signed by the a page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Known 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform Yes 2 No 1 ☐ Yes 2 ☐ No certificate 25. Was case referred to medical examiner?

1 Yes 2 No 26. Place of Death (Check only one) Division of Vital funeral director, Be Inpation Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: Ai completed filled in by the fu Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the only one) 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) 0 1116/12 015552 WJL l e 826 Washing ton Rd. Ste#204 Westminster Md. 21157 3+1VA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

Saiontz

JAN 1 8 2012

31. Date filed (Month, Day, Year)

m.D

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

December American Modes American A				for State Registrar	State of Maryla		artment of F rtificate of I			ene g. No. 🤈 🗀 📘 ′	0 00500
Ame Arunded Pedd can Center Ame Courty Content							3. Time of Death				
## Full full warm of from shadows, pask actual of number) ## Amne Arunded Medical Center ## Anne Arunded Medical Center ##				Margaret Pauline	Pulakos			20, 2012	12:35 A M		
Social Security Function Topic Control T	wa.			4a. Facility Name (If not institution, give s	treet and number)		4b. City, Town, or	Location of Death		4c. County of Dea	ith
181-1376 194	mil P										
The state of the s									(Month, Day,	Year) Co	ountry)
Section Sect		Director		101 10 13/0		115.			May 8,1	923	PA
Stick Stic		rland ow ≡		γ	10c.	City, Town or Lo	cation				10d. Inside City Limits
Stick Stic		Mary a-f sh	ţo	MD Anne Aru	ndel S	everna P	ark				1 □Yes 2 □No
Stick Stic		or 28s	irec	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Co	ountry?
Stick Stic		th wit		711 Oak Grove Cir.			21140	5		USA	
Stick Stic		r dea	nne	11. Marital Status	Armed Forces?	n U.S. 13. \	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)		
Stick Stic	36	s afte	y F		1 □Yes 2 □ No If Yes, Give X		1 □Yes 2 □ No	Specify:		Specify:	White
Stick Stic	00	hour tural	ed b				Λ	ation	T is	6b. Kind of Business	
Physician Medical Examiner Physician Medical Examiner The Control of Physician Medical Examiner The Control	15	in 72 n "na	plet	(Specify only highest grade	completed)	(Give	kind of work done of	during most of work	ing		,
Physician Medical Examiner Physician Medical Examiner The Control of Physician Medical Examiner The Control	212	d with giene rr tha	E		College (1-4or 5+)	Own	er			Stitch &	Knit Shop
Physician Medical Examiner Physician Medical Examiner The Control of Physician Medical Examiner The Control	b	al Hy l othe	3e C	17. Father's Name (First, Middle, Last)				18. Mother's Name	e (First, Middle, M	laiden Surname)	
Physician Medical Examiner Physician Medical Examiner The Control of Physician Medical Examiner The Control	yla	Ment barked	10	Willis Weindorf				Gertrude	Herman		
Physician Medical Examiner Physician Medical Examiner The Control of Physician Medical Examiner The Control	Nar	2 sho and Ism raum									,
Physician Medical Examiner Physician Medical Examiner The Control of Physician Medical Examiner The Control	6,	l and lealtl im 27 ther t									
Physician Medical Examiner Physician Medical Examiner The Control of Physician Medical Examiner The Control	יסר	nt of 1		1 XBurial 2 ☐ Cremation 3 ☐ R	emoval from State			1		ŕ	rown, state
Physician Medical Examiner The second of the second control of th	턆	artme artme ortani injury									
Physician Physic	Ba	Department any language		7 2 - Charles as Service Livers				IIa	-		me P.A.
Playsician (Modifical Examiner) Page Pa				23a. Part 1. Enter the disease, or complic	cations that caused the d						Approximate
Sequentially list conditions, last in the last it process and the control of the	E	Physician		Immediate Cause (Final	e cause on each line.	a Das	(London)	4			Onset and Death
Sourcefully list conditions are consequence of): The following in the limited events resulting in death) Last The following in the limited events resulting in death) Last				resulting in death)	Due to (or as a con-		unorth				
The first of the past 12 months? Part		Examiner		Consensation that constitutions							
The first of the past 12 months? Part	-	p ti	iner	if any, leading to immediate cause. Enter Underlying	Due to (or as a non	весинпон обс					i i
Section Sect		ecute and trans	xam	that initiated events C	Due to (or se a con	seguence of					
FFEMALE 236. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 2 Each death 2	60,	be e) ician burial			Due to (or as a con	sequence ory.					
FFEMALE 236. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 2 Each death 2	387	ficate phys	dic	d							
Second S	×		/Me		3c. If yes, outcome of pre	egnancy				23d. Date of de	elivery
30. Name and address-of person who completed cause of death (Item 23a) (Type, Print) Rebecca famel mo 2001 Medical Parkway Annapolis, mi) 21401	ĕ	death s atte	iciar	in the past 12 months?	4 Pregnant at time			у			
30. Name and address-of person who completed cause of death (Item 23a) (Type, Print) Rebecca famel mo 2001 Medical Parkway Annapolis, mi) 21401	0	t the by the ache	hys	9 ☐ Unknown	9 ∐ Unknown						
30. Name and address-of person who completed cause of death (Item 23a) (Type, Print) Rebecca famel mo 2001 Medical Parkway Annapolis, mi) 21401	S,	ss tha gned se det		Part II. Other significant conditions con	tributing to death but not	resulting in the u	nderlying cause giv	en in Part I.	23e. Did tob		
30. Name and address-of person who completed cause of death (Item 23a) (Type, Print) Rebecca facel mo 2001 Medical Parkway Annapolis, mi) 21401	ord	equire sen si ould t	ed						1 🗆 Ye	s 2 No 3 ☐ F	Probably 4 Unknown
30. Name and address-of person who completed cause of death (Item 23a) (Type, Print) Rebecca facel mo 2001 Medical Parkway Annapolis, mi) 21401	မင	law r as be 2 sh	ple							24b. Were a	autopsy findings available completion of cause of
30. Name and address-of person who completed cause of death (Item 23a) (Type, Print) Rebecca facel mo 2001 Medical Parkway Annapolis, mi) 21401	=	The	Con							ned? death?	21
30. Name and address-of person who completed cause of death (Item 23a) (Type, Print) Rebecca famel mo 2001 Medical Parkway Annapolis, mi) 21401	Vita	Iclen: Sertifi Sctor.		examiner?	itali		O4h		h (Check only one	9)	
30. Name and address-of person who completed cause of death (Item 23a) (Type, Print) Rebecca famel mo 2001 Medical Parkway Annapolis, mi) 21401	of	Phys this c	٦.	ILI 162 ZMINO	1 Minpatient		nt 3 🗆 DOA	4 LI Nursing Ho			ecify)
30. Name and address-of person who completed cause of death (Item 23a) (Type, Print) Rebecca famel mo 2001 Medical Parkway Annapolis, mi) 21401	on	dlng h. After funer	tion	1 Natural 5 ☐ Pending					20d. Describe no	w many occurred	
30. Name and address-of person who completed cause of death (Item 23a) (Type, Print) Rebecca famel mo 2001 Medical Parkway Annapolis, mi) 21401	İSİ	Atten deat ctor: y the	fica	3 Suicide 6 Could not be	28e. Place of Injury - A	At home, farm, str			28f. Location (Str	reet and Number or F	Rural Route Number,
30. Name and address-of person who completed cause of death (Item 23a) (Type, Print) Rebecca facel mo 2001 Medical Parkway Annapolis, mi) 21401	á	al or saffer	erti	4 ☐ Homicide	building, etc. (Sp	ecity)			City or Town	, State)	
30. Name and address-of person who completed cause of death (Item 23a) (Type, Print) Rebecca facel mo 2001 Medical Parkway Annapolis, mi) 21401		fospit 4 hours unere ely fille		(Check only 2 Medical Examin							
30. Name and address-of person who completed cause of death (Item 23a) (Type, Print) Rebecca facel mo 2001 Medical Parkway Annapolis, mi) 21401		thin 24	Medi	one)							
1 Rebecca Pavell MD 2001 Medical Parkway Annapolis, MID 21401		5 5 € 5	_	zau. Signature and title of certifer	00		To Toleris	70210	2	A successioned (Mor	10000
1 Rebecca Pavell MD 2001 Medical Parkway Annapolis, MID 21401		- 4		20 Name and address	mulated agus of door	(Itom 222) (Time	Print)	2074		Thrumy 1	w, will
		811)			- (1	- 10		Parkwa	1 Annar	solis Mi)	21401
		Sta	te	31. Date filed (Montana, 2°as, 201	10013				1	1	

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death ^{Day} 23. Physician/ George E. Pollos 8:30рм 2012 Januaru Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 5828 Littleleaf Court New Market Frederick 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth **Funeral** (Month, Day, Year) 579-54-7432 Director 1 🗶 M 2 🗆 F Yrs 76 April 12,1935 Greece Usual Residence of Decedent 28a-f show 10b. County at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director must be notified 1 Yes 2 X No Maryland Frederick New Market 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 23a u.s.A. 5828 Littleleaf Court 21774 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Black, White, etc. , or þ 1 Never Married 2 X Married Maryland 21215-0036 Yes 2 X No 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify "natural" 3 Widowed 4 Divorced White Completed Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) than Elementary/Secondary (0-12) College (1-4 or 5+) Liquor Distribution should be filed with and Mental Hygien 7 is marked other th Wholesale Liquor Salesperson Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Kalliope Sifakis Emmanuel Pollos other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Heatth ar Important: If item 27 is any injury or other trau 5828 Littleleaf Court, New Market, Maryland 21774 Barbara E. Pollos - Spouse Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Gate of Heaven Cem. 01/28/2012 | Silver Spring, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, 11800 New Hampshire Ave., Silver Spring, MD 20904 1232 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death an creatic Immediate Cause (Final Physician/ mouth disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) nding physician ause as the burial Physician/Medical requires that the death certificate be P.O. Box 68760 IF FEMALE use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Live Birth 2 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? jo 5 Other (specify) Month Day Year the þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? |≥ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law page 2 s autopsy performed? Yes 2 No Dul mun 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 \(\subseteq \text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\subseteq \text{Other} \) Other (Specify) 1 ☐ Yes 2 No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d, Describe how injury occurred within 24 hours after death.

To the Funeral Director: After gompletely filled in by the funer 1 Natural 2 Accident 5 Pending Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of cer 29d. Date signed (Month, Day, Year) ID mI

State Registrar Johnson Drive

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JIMa

31. Date filed (Month, Day, Year)

JAN 25

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Mazie Helen Pruitt 1:30 P M 2012 Medical Jan. Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Hartley Hall Nursing Home Pocomoke City Worcester If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year Nov. 26, 1 **Funeral** Age (In vrs. last birthday) 9. Birthplace (State or Foreign 1 M 2 X F Director 214-10-8515 Yrs. 93 Maryland Nov. 1918 Usual Residence of Decedent or 28a-f show 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f shor other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Worcester Pocomoke City 1XX Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1006 Market Street 21851 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Black, White, etc. ģ 1 Never Married 2 Married ☐ Yes 2 🔀 No Yes, Give Maryland 21215-0036 1 Yes 2K No Specify: Completed 3 X Widowed 4 Divorced white Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 0wner Gas Station 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Oscar Webb Janie Baker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Janet James (Daughter) 38713 James Lane Delmar, DE 19940 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Portersville Cemetery 1-25-2012 Stockton, Maryland Signature of Funeral Service Licensee 22. Name and Address of Facility Short Funeral Home 13 East Grove Street Delmar, DE Yhou LINE 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Immediate Cause (Final DISEAUE Onset and Death ARTERY Physician/ ORON ARY disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, having to immedia cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a nonsequence-of) death certificate be executed physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical attending p 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months? Ectopic pregnancy Year 4 Pregnant at time of death 9 Unknown Day 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 To the Hospital or Attending Physician: The law requires t within 24 hours after death.

To the Funeral Director After this certificate has been sign completed filled in by the funeral director, page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? performed? Yes 2 No 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 No Other: ဂ္ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 1 ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License number D 62173 29b. Signature and tipe of certifi

Box 68760

P.O.

Records,

Division of Vital

DHMH 17 Rev 7/2009

State

Registrar

SHARAD

1. Date filed (Month, Day, Year)

24

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

82. Registrar's Signature

S'ATYAL, MD

62172

1604 MARKET ST. POWMOKE CITY MD 21851.

1/23/2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death MELVIN REYNOLDS Physician/ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Anne Arundel Anne Arundel Medical Center Annapolis Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months Davs Hours 186-28-7296 **Director** 1 M 2 D F 1930 8 81 Virginia March Usual Residence of Decedent 28a-f show 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director Maryland Anne Arundel Annapolis 1 Tes 2X No 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral 438 Poplar Lane 21403 USA death v Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Race - American Indian. Armed Forces?

1 X Yes 2 No Black, White, etc. ģ 1 Never Married 2X Married Baltimore, Maryland 21215-0036 filed within 72 hours after If Yes, Give 1950-56 Year or Dates 1950-56 1 ☐ Yes 2X No Specify. Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) United States al Hygiene. Elementary/Secondary (0-12) 12th College (1-4 or 5+) Engineer Naval Station other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) nd Mental h မ Page 1 and 2 should be Charlie B. Reynolds Vianna White and is m 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Alice N. Reynolds(Wife) 438 Poplar Lane Annapolis, Md. 21403 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State Maryland Veteran 1 - 26 - 12Crownsville, Md. 4 ☐ Donation 5 ☐ Other (Specify) Wmame Reachescof SocilitSons Mortuary, P.A. Signature of Funeral Service Licenses 1922 Forest Dr. Annapolis, Md. 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Ay disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner ARS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): burial-trar Due to (or as a consequence of): resulting in death) Last ed by the attending physician detached for use as the buria Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate bewithin 24 hours after death.

To the Funeral Director, After this certificate has been sinned by the control of the Funeral Director. Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant ☐ Ectopic pregnancy ☐ Other (specify) ____ in the past 12 months? Month Year Yes 2 No signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 WUnknown cate has been signated bage 2 should b CA LUNG AbN PSA 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? MYELOMA death? MULTIPLE 1 ☐ Yes 2 ☐ No 1 Yes 2 No filled in by the funeral director, 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ၀ 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 5 Pending injury 1 Natural 2 Accident Investigation 6
Could not be 3 ☐ Suicide 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 only one) 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DEFENSE HOP ANNAPOLIS 445 LADENTA 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ January 12, 2012 1:55 p м Gwendolyn Rill Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Carroll Lorien Nursing Home Taneytown If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 220–16–2711 Country) MD 1 □ M 2 🖾 F Hours 03/28/1925 Director Usual Residence of Decedent ms 23a or 28a-f show must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Westminster MD Carroll 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21157 USA 2355 Carrollton Road 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. ,0 þ 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2X☐ No Specify: "natural", 3 Widowed 4 Divorced Completed White Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) the Own home Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) Naomi B. Taylor 17. Father's Name (First, Middle, Last) of Health and Mental H fitem 27 is marked ot r other traumatic ever ပ Lionel S. Lockard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) George Rill/husband 2355 Carrollton Road, Westminster, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Department of H Important: If ite any injury or otl 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Finksburg, Maryland Carrollton Ch. of God 1/17/12 4 Donation 5 Other (Specify) gnatur of Funeral Service License 22. Name and Address of FacilitPritts Funeral Home & Chapel, PA Westminster, MD 21157 412 Washington Rd. 23a. Part 1. Enter the disease, or complications that caused the death, Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician Onset and Death disease or condition Medical resulting in death) Due to (or as a conse Examiner Sequentially list conditions If any, reading to immediate cause. Enter Underlying Cause (Disease or iinjury Exami and burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Physician/Medical that the death certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 1 Yes 2 No Day Month Year Pregnant at time of death 5 Other (specify) signed by the a 1 ☐ Yes 2 ¥ 9 ☐ Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? sertension Completed by 2 No 1 Yes 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy Yes 2 No 1 Yes 2 No 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? 2 **N**No 욘 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural iniury work? 1 ☐ Yes 2 ☐ No 5 Pending ☐ Accider ☐ Suicide Accident Investigation

Division of Vital Records, Hospital or Attending Physician: To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director. After this certifical completed filled in by the funeral director, I

WJL 10

Registrar

State

Medical

29a. Certifier

(Check only one)

688-C Poole Rd., Westminster, MD 21157 Tracie L. Ryberg, D.O. 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6 Could not be

JAN 1

determined

32. Registrar's

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

1 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

HO061206

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
amend 6. per fh. 8924 2-6-12 sm.
State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Dolores Jean Ross 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Allegany Western MD Regional Medical Center Cumberland, MD Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Director 1 V M 2 XF 79 220-28-9821 Usual Residence of Dece Jan. 22, 1933 Maryland show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits at Funeral Director notified 28a-f LaVale 1 XYes 2 No Allegany MD 10e. Street and Numbe 10f. Zip Code o 10g. Citizen of What Country? must be 23a 21502 U. S. A. 17 Richard Way items Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ※ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, iral", or iten Examiner r Black, White, etc. ģ 1 X Never Married 2 Married 3altimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: "natural" Completed 3 Widowed 4 Divorced White Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nt of Health and Mental Hygiene.
If item 27 is marked other than or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) 12 Teacher Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Beulah (Turbin) Ross Vernon Joseph Ross 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Ross Cousin 124 Riordan Rd., Westernport, MD 21562 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 🔀 Burial 2 🗌 Cremation 3 🗌 Removal from State Department of Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Feb., 3,2012 Westernport, MD Philos Cemetery Signature of Funeral Service Licensee 22. Name and Address of Facility Hafer Funeral Service, P.A. 1302 National Hwy., LaVale, MD 23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sheck, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Ph_sician/ disease or condition resulting in death) INTRA CEREBRAL HEMORRHAGE Medical Due to (or as a consequence of) **Examiner** HYPERTENSIAN Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examine Due to (or as a consequence or). Cause (Disease or injury that initiated events and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical $\int a \times h / h / h / h = \sqrt{5}$. Division of Vital Records, P.O. Box 68760 use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☑ No Month Day Year the Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed been s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed' 24 hours after death.

Funeral Director: After this certificate 2 No 1 Yes Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 \square Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined ō Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

Controlling Nurse Practitioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

Controlling Nurse Practitioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

Controlling Nurse Practitioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I within 2 To the F or ly or wil 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD 072514 1/31/2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Bev 06-2011

WILLOWBROOK RD, CUMBERLAND, MD, 21502

12500

3. Registrar's Signature

LIV

FEB 0 8 2012

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death Time of Death 1. Decedent's Name (First, Middle, Last) Day Physician/ 1133 Reese, Sr. Kenneth David Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number, c. County of Death Examiner Washington Meritus Medical Center Hagerstown Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday, **Funeral** Min Hours 186-36-3019 65 1 X M 2 □ F Director Yrs. 1946 July 15, Pennsylvania Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State death with the Maryland Director notified 1 X Yes 2 No MD Washington Hagerstown 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ō ms 23a or must be r Funeral 21740 U.S.A. 1435 Howell Road items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. "natural", or iten edical Examiner r Armed Forces?

1 X Yes 2 No Black, White, etc. by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2X No Specify: Specify: Completed 3 X Widowed 4 Divorced White Year or Dates th and Mental Hygiene. 27 is marked other than "natul traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Manufacturing 12 ITD Driver Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Mary Ellen Kuhn David Kenneth Reese 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Heatth as Important: If item 27 is any injury or other traconce. #8 Whitter Hts., MD 21742 Judith A. Reese/Daughter Hagerstown, 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 ,Removal from State 2/1/2012 4 Donation 5 Other (Specify) Rest Haven Cemetery Hagerstown, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rest Haven Funeral Chape 1601 Pennsylvania Ave., Hagerstown 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only cause on each line Immediate Cause (Final Phylician/ disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Physician/Medical P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) Pregnant at time of death been signed by the should be detached a Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Division of Vital Records, Completed 4b. Were autopsy findings available prior to completion of cause of death? page 2 autopsy performed? Yes 2 1 ☐ Yes 2 ☐ No certificate as case referred to medica 26. Place of Death (Check only one) Be examiner? Hospital ၉ 1 Tes ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) To the nusping within 24 hours after death.

To the Funeral Director: After the standard of the funeral of the Certificate: Mann of Deatl 28b. Time of 28c. Injury at work?
1 ☐ Yes 28d. Describe how injury occurred iniury 5 Pending Natural 2 🗌 No Accident Investigation Could not b Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medical Certifying Physi he best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated extitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

DHMH 17 Rev 06-2011

State

only one

29b. Signature and title of certifie

31. Date filed (Month, Day,

30. Name and address of person who con

2 Medical Exam

1110 Medical CarpisRd

ause of death (Item 23a) (Type, Print)

32. Registrar's signature

902

	nd #20b pa			or Print in Black Ir	ndelible Ink. Ensure	All Copies A	re Legible.			
AAC	O Health 1) Dept	ept. 1-25-12 KAH State of Maryland / Department of Health and Mental Hygiene							
			State Registrar	Cer	tificate of Death	Reg.	from Color town Town or the Color to the C			
г	Physicia	n/	1. Decedent's Name (First, Middle, Last) Marlin Smith			2. Date of Death _Month	Day 2012 3. Time of Death 12:30 P M			
Mag	Medic Examin		4a. Facility Name (If not institution, give street and the company of the company	number) rive	4b. City, Town, or Location of Dea		4c. County of Death Anne Arundel			
	Funeral		5. Social Security Number 6. Sex 216–03–4137	7. Age (In yrs. last birthday) F 95 vrs	If Under 1 Year If Under 24 Hr Months Days Hours Mir	8. Date of Birth	9. Birthplace (State or Foreign Country)			
	Director	Ī	Usual Residence of Decedent 10a, State 10b, County	10c. City, Town or Lov	cation	bept. 7,	7916 Maryland 10d. Inside City Limits			
	Marylan 28a-f sh notified	Funeral Director	Maryland Anne Arundel	100.0153, 100.101	Annapolis		1 ☐ Yes 2 👿 No			
	h with the	neral [10e. Street and Number 1201 River Crescent Dr		10f. Zip Code 21401		Citizen of What Country?			
920	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ρ	1 Never Married 2 Married 1 Never Married 2 If Yes,	es 2 No	Was Decedent of Hispanic Origin? (5 f Yes, specify Cuban, Mexican, Pue □ Yes 2 X No Specify:	Specify Yes or No- to Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White			
21215-0036	72 hour	Completed	15. Decedent's Education (Specify only highest grade comple	(Give	dent's Usual Occupation kind of work done during most of wo O NOT use retired)	orking 16t	b. Kind of Business/Industry			
	within /giene. ner th a t, the I		-	e (1-4 or 5+) Air	Force Officer		U.S. Air Force			
Maryland	d be filed Mental Hy arked ott	To Be	17. Father's Name (First, Middle, Last) John Paul Smith		18. Mother's Nargi	ame (First, Middle, Maid lerite Robe	len Surname) Its			
, Mar	id 2 shoul salth and I n 27 is m er traums		19a. Informant's Name/Relationship (Type, Print) Marlin Smith, Jr./son	19b. Mailir 734	ng Address (Street and Number or F Holly Drive Ann	ural Route Number, City Napolis, Ma	y or Town, State, Zip Code) ryland 21409			
Baltimore,	Page 1 ar lent of He nt: If iten ry or oth		20a. Method of Disposition 1 ★★Burial 2 □ Cremation 3 □ Removal for 4 □ Donation 5 □ Other (Specify)		sition (Name of natory or other place) Nat. Cem. 2/2	Hnk	c. Location - City or Town, State			
Balti	permit. Popartra limporta any inju		21. Signature of Funeral Service Licensee Meellon T. Holes		Name and Address of Facility JC	hn M. Tayl				
F	-		23a. Part 1. Enter the disease, or complications the shock, or heart failure. List only one cause or	at caused the death. Do not ente			Approximate Interval Between			
Said.	Physician/		Immediate Cause (Final disease or condition	· V News	ardial inters	tion	Orset and Death			
	Medical Examiner			to (or as a consequence of):	Ü					
	ited d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury	to (or as a consequence of):						
0	be executed sician and burial-transi	_	that initiated events resulting in death) Last	to (or as a consequence of):						
68760	ificate ng phy as the	Medi	IF FEMALE:							
. Box	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Completed by Physician/Medica	23b. Was decedent pregnant in the past 12 months?	outcome of pregnancy ive Birth 2 Fetal death 3 regnant at time of death 5 Inknown	Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year			
s, P.O	es that t signed b	d by P	Part II. Other significant conditions contributing	1 11		23e. Did tobace	co use contribute to the cause of death?			
ord	requi	lete		arrhithm	v. q. v.	24a. Was an	24b. Were autopsy findings available			
Records,	sician: The law is certificate has the lirector, page 2 s	Som				autopsy performed	prior to completion of cause of death? Yes 2 No			
Vital	cian: certific ector,	Be	25. Was case referred to medical examiner?		26. Place of Death (Ch	eck only one)				
of Vi	Physi r this c eral dir	은 -	1 Yes 21 No 1 27. Manner of Death 28a. D	Inpatient 2 ER/Outpatier ate of injury 28b. Time of		Home 5 Residence	e 6 Other (Specify)			
ion	tending Seath. tor: Afte	tificat	2 Accident Investigation	Month, Day, Year) injury	work? M 1 ☐ Yes 2 ☐ No					
Division	To the Hospital or Attending Physician: The la within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Medical Certificate:	4 - Horricide determined by	ace of Injury - At home, farm, struilding, etc. (Specify)		City or Town, Si				
	he Hosp in 24 hou he Funei ipletely fi	Medic	(Check 2 Medical Examiner: On the	basis of examination and/or inves	occurred at the time, date and place tigation, in my opinion, death occurred death occurred at the time, date and	d at the time, date and pl	lace, and due to the cause(s) and manner stated.			
•	To the within 5 To the comple		29b. Signature and title of certifier	Eden, MO	29c. License number 3 0 7 0	29d.	Date signed (Manth, Day, Year)			
	5CH.		KNOCK+ SPOKK FORN, MO	ause of death (Item 23a) (Type, F	PRWY Suite G	to Annan	1115, MD 21411			
	Stat Registra	e ir	31. Date filed (Month, Day, Year) 33. JAN 2 4 2012	2. Registrar's Signature	and					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State O	f Maryland / D			Mental Hyg	giene	2 03537
			Registrar 1. Decedent's Name (First, Middle, Last)		Certificate o	Deam	2. Date of Dea	Reg. No. 💪 🔾 📗	3. Time of Death
	Physicia		Alison J S	NAVGO			Januari	Day Yea	ar 0000 AM
	Medic Examin		4a. Facility Name (if not institution, give street and num.	er)	4b. City, Towr	n, or Location of Deat		4c. County of D	
زر			1308 Bristol Ridge Place		C	rownsvill	2	Anne Aı	cundel
1	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birth	day) If Under 1 Ye Months Da			9. (Year)	Birthplace (State or Foreign Country)
	Director		261-48-8597 1 ☐ M 2 🕮	77	rs.		5/24/19	934	" FL
	nd how at		10a. State 10b. County	10c. City, Town	or Location				10d. Inside City Limits
	faryla 8a-f s ified	Director	MD Anne Arundel		Crowns	ville			1 ☐ Yes 🎞 No
	the N n or 29		10e. Street and Number		10f. Zip Cod			10g. Citizen of What	
	n with	Funeral	1308 Bristol Ridge Place			21032		USA	A
	death r item ner n		Armed For		13. Was Decedent of If Yes, specify C	of Hispanic Origin? (S uban, Mexican, Puerl	pecify Yes or No- o Rican, etc.)	14. Race - A Black, W	merican Indian, /hite, etc.
36	72 hours after death with the Maryland n "natural", or items 23a or 28a-f sho fledical Examiner must be notified at	d by	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 3 ★★Widowed 4 ☐ Divorced Year or Da	9	1 ☐ Yes 2 X	No Specify:		Specify:	White
21215-0036	hours natura iical E	Completed	15. Decedent's Education	16a.	Decedent's Usual Oc			16b. Kind of Busine	ess/Industry
215	in 72 e. nan "r	ᇤ	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-	4 or 5+)	(Give kind of work do life. DO NOT use retir	red)			
2	within ygiene. her thar tt, the N	ادها	2		Technical			Defe	ense
Maryland	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	To B	17. Father's Name (First, Middle, Last)				me (First, Middle,		
Ž	should be file and Mental I is marked o raumatic eve	ľ	Harry David Jones 19a. Informant's Name/Relationship (Type, Print)	106	Mailing Address (Stre		son Ball		Zin Code)
\mathbf{Z}	2 shou Ith and 27 is m r traum		Patricia Benson Daught		19 Crossla			MD 21113	, zip oodo)
ē,	ge 1 and 2 sl it of Health a if item 27 i or other tra		20a. Method of Disposition	20b. Place of	Disposition (Name of		Date	20c. Location - City	or Town, State
m 0	Page nent or nent or nent or nent or nent or nent if in nent if in or nent or		1 ☐ Burial 2XX Cremation 3 ☐ Removal from 4 ☐ Donation 5 ☐ Other (Specify)	otate -	y, crematory or other ic Cremato	1 - 1 -	1/2012	Crownsvi	lle, MD
Baltimore,	permit. Page 'Department or Important: If any injury or once.		21. Signature of Funeral Sentice Licensee		22. Name and Ad	dress of Facility Ha			
<u>m</u>	27 = 2		18 4. Ch		12 Ridge		-	s, MD 2140	01
			23a. Part 1. Enter the disease, or complications that c shock, or heart failure. List only one cause on ea	aused the death. Do no ch line.	ot enter the mode of	dying, such as cardia	or respiratory arr	est,	Approximate Interval Between Onset and Death
	nyuician/ Medical	16.3		ntracere		morrha	1e		a weeks
\sim	Examiner		Due to (or as a consequence o	n: Notion		J		ONE year
	3	ner	Sequentially list conditions, if dry, leading to kn mediations. During the knowledge cause. Enter Underlying	r da abunsequience o	The Park				ONEGO
	d d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.						
	exec	Ē	resulting in death) Last Due to (or as a consequence o	f):				
9	death certificate be executed he attending physician and led for use as the burial-transit	dical	d		 				
687	ertifica ding p	₩.	IF FEMALE: 23c. If yes, out	come of pregnancy				23d. Date of	f delivery
Вох	ath o atten I for u	ciar	in the past 12 months?	Birth 2 ☐ Fetal death nant at time of death	3 Ectopic pregr 5 Other (specif)			Month Month	Day Year
B	the de sy the achec	Physician/Me	9 Unknown 9 Unkn	own		_			
P.O.	requires that the death been signed by the atte should be detached for	by P	Part II. Other significant conditions contributing to de	eath but not resulting in	n the underlying caus	e given in Part I.			e to the cause of death?
ds,	quires en siç ould b	Completed by	Obesity	-			1 🗆		Probably 4 Unknown
00	has be	nple	, , , , , , , , , , , , , , , , , , , ,				24a. Was autor	osy prior	e autopsy findings available to completion of cause of
Be	: The lar cate har r, page						1 Yes		Yes 2 No
ita	ysician; The is certificate director, pag	Be c	25. Was case referred to medical examiner? 1 Yes 2 No Hospital:		_	Other:			
of V	Physer this eral di	e: To	27. Manner of Death 28a. Date	Inpatient 2 ER/Out of injury 28b. T	ime of 28c. I	4 □ Nursing njury at		dence 6 Other (S	pecify)
on c	nding I ath. r: After ie funer	icat	1 Natural 5 Pending (Monit	h, Day, Year) ir		vork? 			
Division of Vital Records,	r Atte	Certificate:	3 Suicide 6 Could not be 28e. Place 4 Homicide determined	of Injury - At home, far	m, street, factory, offi	ce	28f. Location (S		Rural Route Number,
ă	Hospital or Atten 24 hours after deat Funeral Director: stely filled in by the								
	Hosp 24 ho Fune stely f	Medical	29a. Certifier 1 Certifying Physician: To the b	is of examination and/or	r investigation, in my o	pinion, death occurred	at the time, date a	and place, and due to	the cause(s) and manner stated.
	To the Hospital or Attending Physician. The law requires that the within 24 hours after death. To the Funeral Director. After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detach.	Σ	only one) 3 Certifying Nurse Practitioner 29b. Signature and title of certifier	io the pest of my know		ense number	piace, and due to t	ne cause(s) and mann 29d. Date signed (M	
	F>F0		> 23 Kitham	MD		D29193			
	.0		30. Name and address of person who completed caus	e of death (Item 23a) (Type, Print)	C.		141)	20,20/2 37
	iw		3.00	69 Bran	exton & #	201; cdg	choster	MD 210	3 /
	Sta Registr		31. Date filed (Month, Day, Year) JAN 2 4 2012 32. R	gistrar's Signature	pare	V	,		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Manyland / Department of Health and Mental Hygiene

	1	For State Registrar	State of Marylar		tificate of D			Reg. No. 🦳	010	000
Dharisia		1. Decedent's Name (First, Middle, Last)					2. Date of Dea		Year	3. Time of Deat
Physicia Medic	al .	William Bradfor As. Facility Name (if not institution, give str		ugh		Lastin of Dooth	Jan.	16 ^{Day} 20	y of Death	9:42
Examin	er	a. Facility Name (if not institution, give str Golden Living N		e	Westmi	Location of Death		Carı		
Funeral Director		5. Social Security Number 6. Sex 17-03-9794 1 [28]	7. Age (In yrs. 94		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da) 3/28/1	y, Year)	9. Birthp Coun MD	olace (State or For try)
a-f show	Director	Usual Residence of Decedent 10a. State 10b. County MD Carrol		ty, Town or Lo Iampste			<u> </u>		1	10d. Inside City Lir
23a or 28 ust be not	Funeral Dir	10e. Street and Number 3100 Hoffman Mill	Road		10f. Zip Code 21 0			10g. Citizen of USA		ntry?
tal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates.	1	Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 🔀 No		ecify Yes or No- Rican, etc.)	Specif	ice - Americ ack, White, fy: whi	etc. te
ygiene. her than "natu t, the Medical	Completed	15. Decedent's Edur (Specify only highest grade Elementary/Secondary (0-12)		(Give life. D	dent's Usual Occup kind of work done o O NOT use retired)	luring most of work	ing	16b. Kind of E		
ental Hygie ked other ic event, ti	a l	17. Father's Name (First, Middle, Last) James Swartzbaugh		THOUSE	e & Caccit	18. Mother's Nan	ne (First, Middle, e Owing	Maiden Surnan		
h and M		19a. Informant's Name/Relationship (Type Lillian Clendaniel			ng Address (Street	and Number or Rui	al Route Numbe	er. City or Town.	State, Zip	Code) 57
nent of Healt ant: If item 2 ury or other		20a. Method of Disposition 1	20b. emoval from State	Place of Dispo	osition (Name of matory or other place Cem.	re) 1/21	Date /2012	20c. Location West		own, State
Department of Important: If i any injury or once.		21. Signature of Funeral Service Licensee January 23a. Part 1. Enter the disease, or compline	emmer_	9	2. Name and Addre	in St., F	ine Fun Iampstea	d, MD 2		
Medical Medical is the burial-transi	edical Examiner	shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consec	quence of): quence of):	aler D	sease				Interval Betwee Onset and Peat
the attending physched for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregr 1 ☐ Live Birth 2 ☐ Fe 4 ☐ Pregnant at time o 9 ☐ Unknown	tal death 3	☐ Ectopic pregnan☐ Other (specify)	су			Date of deli	very Day Year
within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi	Completed by Ph	Part II. Other significant conditions con	tributing to death but not re	esulting in the	underlying cause g	ven in Part I.	1 24a. Was	Yes 2 No	b. Were autoprior to codeath?	the cause of death
ificate or, pa		25. Was case referred to medical			26. F	lace of Death (Che		2 X No	T L res	2 🗆 No
nis certificate has t I director, page 2 s	To Be	examiner? 1 ☐ Yes 2 🗗 No	ospital: 1 🔲 Inpatient 2	☐ ER/Outpatie	ent 3 🗆 DOA Oth	ner: 4 📉 Nursing H	lome 5 🗆 Res	idence 6 0	ther (Speci	fy)
ar death. ector: After th by the funeral	Certificate:	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	28a. Date of injury (Month, Day, Year) 28e. Place of Injury - At	28b. Time of injury	M 1	ry at k?] Yes 2 \(\sum \text{No} \)		how injury occu		al Route Number,
ours after eral Direc		4 Homicide determined 29a. Certifier 1 rtifying Physi	building, etc. (Spec	ify)	occurred at the tim	ne, date and place,	City or To	wn, State)	anner as sta	ated.
	Medical	(Charle O Modical Evamin	er: On the basis of examinate Practitioner: To the best of	ion and/or inve	stigation in my opin	ion, death occurred the time, date and	at the time, date	and place, and	due to the d	s stated.
WJL 4		20 Name and address of person who co	ompleted cause of death (It	em 23al (Type,	Print) P	143		1/16	120	0/4
Sta	ate	31. Date filed (Month, Day, Year)	32. Régistrar's Sign	nature	hadi	TAE AN	nmal	4	11	5 /

Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - StateAmmened Box 20B Per FH WSH Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ STOCK 06:58AM Janyan 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** University of Maryland Medical Center Baltimore If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Hours Director 1 M 2 □ F 217-36-4784 2/7/1931 MD 80 Usual Residence of Deced 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County with the Maryland Funeral Director Hampstead MD Carroll notified 28a-f 1 Yes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? ō must be n USA 411 Lees Mill Road 21074 Page 1 and 2 should be filed within 72 hours after death \u00e4ment of Health and Mental Hygiene. items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian 11. Marital Status Black, White, etc. ö ģ 1 Never Married 2 Married 🗌 Yes 2🗶 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: white "natural" Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4 or 5+) self employed farmer farming other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) alth and Mental H 27 is marked of ir traumatic ever မ Beulah V. Lippy Arthur E. Stocksdale, Jr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 35 Preakness St., Hanover, PA 17331 Karen Coleman, daughter Department of Health Important: If item 27 any injury or other the once. 20a. Method of Disposition Date 20c. Location - City or Town, State 20b. Place of Disposition Name of 1X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hampstead Cemetery 1/17/2012 |Hampstead, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility M00741 Eline Funeral Home Hampstead, MD 21074 <u>934 S. Main St.,</u> 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician, ootension disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner intrac week Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last and the burial-tran Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Day 5 Other (specify) been signed by the a should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an cate has autopsy 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 🗌 Yes 2 No 1. Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending
Investigation Natural work? 1 ☐ Yes 2 ☐ No 24 hours after death. Funeral Director: A Accident filled in by the Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 24 hor To the Fune completely fi 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 101539 WJL 2012 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Green Street Baltimore Mayland 21201 Heather Micha 22 N 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 1 Registrar

		Pleas	se Type or Prin						-		gible.	
		For State	State of Ma	aryland / [and M	lental Hy	giene	0.10	0051.0
4		Registrar	f		Certificat	te of L	<i>Death</i>		-	Reg. No. 🧶	U16	00040
Physicia Medic		1. Decedent's Name (First, Middle, Juanita	E. Smith						2. Date of Dea Month Jan Jany	Day 20th	Year	3. Time of Death
Examin	er	4a. Facility Name (if not institution, g		-i+-1	4b. City		Location o		•	4c. Coun	ty of Death	~
Funeval		Southern Mar 5. Social Security Number 6		pital (In yrs. last birti	nday) If Unde	er 1 Year	into		8. Date of Birtl	<u> </u>	P.(place (State or Foreign
Funeral Director		578-58-6381 Usual Residence of Decedent	1 🗆 M 2 X]E		Months Yrs.		Hours	Min.	(Month, Day	, Year)	Cour	
and show	or	10a. State 10b. County		10c. City, Town	or Location							10d. Inside City Limits
Maryla 28a-f	rect	MD P	.G.		Oxon H	ill						1 X Yes 2 □ No
h the	Funeral Director	10e. Street and Number	7 7	// m 2	10f. Zi	p Code	00745			10g. Citizen o	What Cou	-
ith wii ms 2; musf	ner	703 Audrey L	12. Was Decedent Ev		12 Was Door		20745		cify Yes or No-	44 P		
or ite	by Fu	11. Marital Status1 ☐ Never Married 2 ☐ Marrie	Armed Forces?	Ver III 0.5.	If Yes, spe	cify Cuba	n, Mexican	, Puerto F	Rican, etc.)		ice - Americ ack, White,	
urs aftural",		3 🖁 Widowed 4 🗆 Divorced	If Yes, Give Year or Dates.		1 🗆 Yes	2 No	Specify:		_	Specia	^{Бу:} В.	lack
2 hou "natu	Completed	15. Decedent (Specify only highest	's Education ! grade completed)	16a.	Decedent's Usu (Give kind of wo	ork done a	ation during most	of working	ng	16b. Kind of	Business/Ir	ndustry
ithin / ene. r than	Con	Elementary/Secondary (0-12)	College (1-4 or 5-	+)	life. DO NOT us	eretired) mest	ic			Но	nemal	ker
lled w Hygi othe	Be	17. Father's Name (First, Middle, La	st)				18. Mothe	er's Name	(First, Middle,	Maiden Surnar	ne)	
d be f Menta arked	7	James Hi	.cks					Ce	celia	Frank	lin	
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or items 29a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationship Rosemary Fran		ter 19b	. Mailing Addr	03 ^{reet} A	and Number	r or Rural	Route Number	City or Tawn,	State, Zip	Code)
1 and f Heal item 2		20a. Method of Disposition	triii, baagii	20b. Place of	Disposition (Na	me of			ate 207	20c. Location		
page lent of nt: If ny or		1 X Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Sp		Harmo	y, crematory or ny Mem	other plac • C∈	em . 1	-26	-2012	Land	over	, MD
rmit. P partn porta y inju		21 Signature of Funeral Service Lic	ensee		22. Name a	nd Addres	ss of Facility	y The	House			ns Funeral
9 8 E 8		Yanu W.	ullani T	799	& Cren	n. Sr	vcs/	814	Upshu	rst,	NW/WE	ash, DC 200
		23a. Part 1. Enter the disease, or c shock, or heart failure. List on	ly one cause on each line.							est,		Approximate Interval Between
Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a	vdiop.	s(mona)	ry C	Colla	PSR				Onset and Death
Examiner		1	Due to (or as a	consequence of	tensio	7 /	f h	2	dial			DAYS
	ner	Sequentially list conditions, if any, leading to immediate	Due to (or as a	consèquence d)T):		77 11	Coll	see (and	, 0		
nd nd Transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c	sepsin	Syndr	ome						DAYS
be executed sician and burial-transit	cal E	resulting in death) Last	کم Due to (or as a	consequence of	icrobio	Q I	n Lo.	tia	n			weeks
physics the b			d				7 60					
eath certificate b attending physi d for use as the b	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome o							23d. D	ate of deliv	rery
e atte	sicia	in the past 12 months? 1 Yes 2 No	1 Live Birth 2		3 L Ectopic 5 Other (s		;y			1	fonth	Day Year
t the c by th	Phys	9 Unknown	9 Unknown		- 41		on in Deat I		1			
es tha signed I be de	by	Part II. Other significant condition Mov 5: 2	Sesity	at not resulting i	n the underlying	cause giv	en in Part i	١.	23e. Did to			he cause of death?
requir been s should	etec	8.2.	1		p. 44							ppsy findings available
e law e has b	Completed	Clamo	Pulmonar	H. (.	a itom	Cò	n		24a. Was a autop perfo	rmed?	prior to co death?	ompletion of cause of
nysician: The lav nis certificate has I director, page 2	e Co	25. Was case referred to medical	Polmaner	7 174/	ver (ev	26 Pl	ace of Deat	th (Check	1 Yes	2 00	1 Yes	2 No
ysicia is cert direct	To Be	examiner? 1 Yes 2	Hospital:	nt 2 🗆 ER/Ou	tpatient 3 🗆 🗈	Othe	ar.		ne 5 🗆 Resid	ence 6 🗆 Ot	her (Specif	y)
ng Ph fter th ineral	te:	27. Manner of Death 1. Natural 5 □ Pending	28a. Date of injury (Month, Day,		ime of njury	28c. Injury work	/ at		8d. Describe h	-		
ttendi death. tor: A the f	Certificate:	2 Accident Investiga	ation		М		Yes 2 🗌	_				
I or Ai after Direc d in by		4 ☐ Homicide determin	28e. Place of Injur building, etc.	ry - At nome, fai . (Specify)	m, street, ractor	у, опісе		2	28f. Location (S City or Tow		ber or Hura	l Route Number,
To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physompletely filled in by the funeral director, page 2 should be detached for use as the	Medical		Physician: To the best of n aminer: On the basis of ex									
the F thin 24 the F mplet	Me		Nurse Practitioner: To the		vledge, death oc	curred at t	he time, dat		ce, and due to the	ne cause(s) and	manner as	stated.
P = 5 P 2		29b. Signature and title of certifier M. M. Loce	I fame		29	c. License	≤ number	15		29d. Date sign		
•		30. Name and address of person wi		eath (Item 23a)	Type, Print)	100	792	<u>U</u>			77	
		K. Michael FIGARO	MD. 12150 A	nnapolis	Rd. S.	ite 20	00 (slen.	n Dale,	MD	2074	>9
Stat		31. Date filed (Month, Day, Year)	32. Registrar	r's Signature	artes,							
Registra	ar i	TARE ZO /III	10 16-16	N. H	-							

1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 JoAnne Sickmen 2:15рм January Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death Collingswood Nursing Home Rockville Montgomeru 5. Social Security Number If Under 1 Year 8. Date of Birth (Month, Day, April 2 7. Age (In yrs. last birthday) If Under 24 Hrs Funeral 9. Birthplace (State or Foreign 1 M 2 X F Months Days Hours Washington, DC 216-40-5867 Yrs **Director** Usual Residence of Decedent 28a-f shov 10a State 10b. County within 72 hours after death with the Maryland at 10c. City, Town or Location 10d. Inside City Limits Director Examiner must be notified 1 Yes 2 X No Maryland Rockville Montgomery ò 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 13615 Cherrydale Drive 20850 tems 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc. 1 Never Married 2 Married "natural", or δ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 X No Specify: 3 Widowed 4 X Divorced Specify Completed White the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Credit Manager Retail/Finance Be 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be file Department of Health and Mental H Important: If item 27 is marked any injury or other 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Herman Eig Jesse Glassman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eric Astran - Son 3300 Velvet Valley Drive. West Friendship.MD 21794 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Lebanon Cemetery 01/23/2012 4 ☐ Donation 5 ☐ Other (Specify) Adelphi, Maryland 21. Signature of Euneral Service Licer 22. Name and Address of Facility Hines-Rinaldi Funeral Home. Inc. 11800 New Hampshire Ave., Silver Spring, MD 20904 or complications that caused the only one cause on each line. 23a. Part 1. Enter the dishock, or heart fail. death. To not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine and Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical P.O. Box 68760 for use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☑ No Pregnant at time of death Month Day Year signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 : autopsy performed After this certificate has 1 Yes within 24 hours after death.

To the Funeral Director; After this certific completed filled in by the funeral director, 25. Was case referred to medical **Division of Vital** Be 26. Place of Death (Check only one) examiner?
1 Yes Hospital: 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 0062435 30. Name and address of person who comp

Registrar

State

25

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1 Decedent's Name (First Middle Last 2. Date of Death Physician/ Month Thelma Scuka 8:50a M 24. January 2012 Medical 4a. Facility Name (if not institution, give street and number 4b. City. Town, or Location of Death Examiner 4c. County of Death 3142 Gracefield Road, Prince George's Silver Spring Social Security Number If Under Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Hours 523-18-3866 Director 1 🗆 M 2 🗶 F 94 02/10/1917 Colorado Usual Residence of Decedent 28a-f show with the Maryland at 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits Director notified 1 Yes 2 No Maruland Prince George's Silver Spring 10e. Street and Number 0 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a o Funeral 20904 3142 Gracefield Road, #317 U.S.A. death v 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 72 hours after If Yes, Give Year or Dates 1 Yes 2 X No Specify. Specify 3 XWidowed 4 Divorced Completed White. Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working than life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other tha the Realty Realtor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, 2 e 1 and 2 should be of Health and Menta Thomas Jefferson Evans Florence Lloyd 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t: If item 27 is or other tra Dona Sandefur - Daughter 1513 Castle Cliff Pl., Silver Spring, MD 20904 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Department or Important: If any injury or once. Lincoln Crematory 01/31/2012 Brentwood, Maryland 4 Donation 5 Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility Hines-Kinaldi Funeral Home. Inc. MENAL 11800 New Hampshire Ave., Silver Spring, MD 20904 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Retween Immediate Cause (Final - Physician/ Acute Renal Failure disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Years Congestive Heart Failure oequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) that the death certificate be executed and Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) Live Birth 2 Live Fetal Social Pregnant at time of death in the past 12 months?

1 Yes 2 No Month 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 LUnknown Hypertension page 2 should Were autopsy findings available prior to completion of cause of death? 24a. Was an Coronary Artery Disease has After this certificate 1 \(\text{Yes} \) 1 ☐ Yes 2 X No 2 No or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 2 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 🛮 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

eral Director: After this filled in by the funeral within 24 hours a the Hospital

(Check

only one) 29b. Signature and til

D24035 January 24, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) E.S. Machado, 3110 Gracefield Road, Silver Spring, Maryland 20904 M.D.. 31. Date filed (Month, Day, Year, 32. Registrar's Signature JAN 25 2012

Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29d. Date signed (Month, Day, Year)

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

State

Registrar

Please Type or Print in Black Indelible Ink. Ensure 21 Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month ANBOWER John ZďZ 1000 George. 0 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner Town, or Location of Death Medical A005/an WOSTIN Security Number 7. Age (In vrs. last birthday) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 220-34-0757 **Director X** X M 2 □ F 73 Nov.28,1938 Maryland Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "naturor" any injury or other traumatto averant of the property. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** 1 Yes 2 No Md. Washington Smi thsburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A 23468 Whitetail Rd. 21783 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 V Yes 2 No If Yes, Give Year or Dates. 5 1 Yes 2 No Specify: Specify: Completed 3 X Widowed 4 □ Divorced 56-57 White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Board of Education Maintence Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Gladys Marie Law Herbert Lee Sanbower . Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code). 86 Creek Rd. New Port, Pa. 17020 19a. Informant's Name/Relationship (Type, Print) Frank W. Sanbower (Son) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Smithsburg Crematory Smithsburg, Md. 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility 12525 Bradbury Ave.) Char M01414 كناب J.L. Davis Funeral Home 21783 Smithsburg, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ GOSTOINESTIND disease or condition Medical resulting in death) **Examiner** Suspected Upper Gastrointestinal bleed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician by Physician/Medical Division of Vital Records, P.O. Box 68760 the for use as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) Live Birth 2 Fetal deat
Pregnant at time of death in the past 12 months?
1 Yes 2 No Month Day Year been signed by the a should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Witness - INDB, 19 5 MOCENE Block 10 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an Idiopathic cirrhosis cate has l autopsy perform certificate 25. Was case referred to medical funeral director. Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes ✓ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Manner of Death Certificate: Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After Natural (Month, Day, Year) 5 Pending work 1 Yes 2 No Accident Investigation filled in by the Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one) the Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29c. License number 0005301 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Medical Merity BASAN State Registrar

8

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene
Amend Items 29c,30 per dr., g924, U2/08/2012dhb
Certificate of Death
Reg, No 1 - State 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Michael Allan Smith 0058 M muan Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death **Examiner** Washington Meritus Medical Center Hagerstown Birthplace (State or Foreign Country) Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Months 220-32-2713 1 🛣 M 2 🗀 F 78 Aug. 5, 1933 Maryland Usual Residence of Decede 28a-f show 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Director 1 Yes 2X No Cascade Washington Maryland 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 21719 U.S.A. 25455 Highfield Road 12. Was Decedent Ever in U.S. Armed Forces? Arm 1 🔀 Yes 2 🗆 No 195 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Army 1957 Black, White, etc. þ 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify. Specify. 3 Widowed 4 Divorced White Completed 1959 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) *Administrative Assistant* Education 5+ Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Allan Smith Margaret Shaffer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 25455 Highfield Rd. Cascade, Maryland 21719 Department of Health Important: If item 27 any injury or other to once. Kathryn Smith (Wife) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State cemetery, crematory or other place, Januaru 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crematory 2012 Signature of Funeral Service Licensee 22. Name and Address of Facility J.L. Davis Funeral Home MO 1414 12525 Bradbury Ave. Smithsburg, Maryland 21783 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner as a consequence of Cause (Disease or injury that initiated events resulting in death) Last the burial-tran and attending physician Physician/Medical for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Line of death
Pregnant at time of death
Unknown 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year should be detached signed by the Part II. Other significant co. ditions contributin , o death but not resulting in the underlyin 🔑 se given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Yes Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an performed Yes 2 2 🗌 No 1 Yes 25. Was case referred to meg 26. Place of Death (Check only one) examiner?

Director Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant. If item 27 is marked other than "natural", or items 23a or 28a-f sho ury or other traumatic event, the Medical Examiner must be notified at ury or other traumatic event, the Medical Examiner must be notified at Baltimore, Maryland 21215-0036 Smithsburg, Maryland Physician/ Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed P.O. Box 68760 Division of Vital Records. ieral Director: After this certificate has filled in by the funeral director, page 2. 24 hours after death.
Funeral Director: After this certificate Be Hospital: Other: 4 \(\sum \) Nursing Home 5 \(\sum \) Residence 6 \(\sum \) Other (Specify) 2 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manne Certificate: Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No 2 Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homici determined Medical 29a. Certifier rtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. one) the within To the 29c. License number 29b. Signature a D71902 erson who completed cause of death (Item 23a) (Type, Print) 30. Name and addu Mark Sullivan, MD, 11110 Medical Campus Road, Hagerstown, MD 21742 5 31. Date filed (Month) State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar AMEND@OaperFH, 1/25/12; BMW, McCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 11:30 PM 2012 Januar) Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death Regional Hospital Prince George aure Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Foreign 1 DM 2 K Months 218-81-0435 Hours 40 Yrs. Director or 28a-f show 10a. State 10h County 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director (20000 1 Yes 2 No 10e. Street and Number 10f. Zip Code Citizen of What Country? items 23a Funeral death with ane13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian Black, White, etc. Armed Forces' ori permit. Page 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examir 1 Never Married 2 Married Completed by Yes 2 X No Baltimore, Maryland 21215-0036 1 X Yes 2 ☐ No Specify: C If Yes, Give 3 🗌 Widowed 4 🗆 Divorced Specify. Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) None None Be 17. Father's Name (First, Middle, Last 18. Mother's Name (First, Middle, Maiden Surname) ပ္ esus 19a. Informant's Name/Relationship (Type, Print) Husband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20a. Method of Disposition 20b. Place of Disposition (Name of 1 A Burial 2 Cremation 3 cemetery, crematory 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Breast Metastati disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed and resulting in death) Last Due to (or as a consequence of): physician at the burial-Physician/Medical P.O. Box 68760 the attending phone of the transfer of the tra IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year been signed by the should be detached 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy perform Yes 2 N 2 **X**No 25. Was case referred to medical Be B 26. Place of Death (Check only one) examiner? 1 Yes 2 2 No 1 X Inpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director. After the completed filled in by the funeral up. 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Suicide Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town. State Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Number Practionars To the basis of my knowledge, death continued at the time, date and place and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifie 29c. License number 29d. Pate signed (Month, Day, Year) 70093 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Valn Dusen Road 7300 MD Laurel Regional Hospita Gorantla, -aurel 31. Date filed (Month, Day, Year)

JAN 25 State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Physician/ 430 am Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death County of Deat Examiner curet rofton Annet 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth Funeral 1 🗆 M 2 💢 F Months Days Hours Min (Month, Day, Ye 68 Maryland Director 1947 Aug. Usual Residence of Decedent or 28a-f show 10a, State 10c. City, Town or Location r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 XNo MD Anne Arundel Crofton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1721 Fallowfield Court 21114 USA hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. δ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🕅 No Specify: Specify. Completed 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 Switch Operator Verizon Be injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Dorothy Cooper Rov Buckwalter permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke, any injury or other traumatic e 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donna M. Marx-Niece 3241 Quail Dr., Huntingtown, Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetry, crematory or other 20c. Location - City or Town, State Burial 2 XCremation 3 Removal from State Metro Crematory 1-23-2012 Baltimore, MD 4 Donation 5 Dother (Specify) e Service Lie 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy, Bowie, MD 20715 Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) that the death certificate be executed sician and burial-trans Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical IE EEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Month Pregnant at time of death signed by the a 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No 3 Probably 4 Unknown cate has been signated by page 2 should by Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate Yes 2 No Hospital or Attending Physician: 124 hours after death. Funeral Director: After this certifica eted filled in by the funeral director, p. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 1 No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 5 Pending 2 🗌 No 2 Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide determined City or Town, State) hin 24 hours af the Funeral Di npleted filled ir Medical 29a, Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only Signatu 29c. License number 29d. Date signed (Month. Dav. Year) 2 and address of person who completed cause of death (Item 23a) (Typo Print) Glen. Bunie, My 21061 State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 03547 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2012 Charles William Weidner 10:15 p^M January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Frederick St. Joseph's Ministries Emmitsburg Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** (Month, Day, Year) Dec_5, 1947 Days 1X M 2 - F Months 64 Yrs 214-48-2535 Pennsylvania Director Usual Residence of Decedent or 28a-f show notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Emmitsburg Frederick 1 Yes 2 No Maryland 10e. Street and Number 10g. Citizen of What Country? ö 10f. Zip Code er than "natural", or items 23a or the Medical Examiner must be Funeral 21727 331 S. Seton Avenue USA 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. \$ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 X No Specify. white Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 hand Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Manufacturing Laborer 10 permit. Page 1 and 2 should be filed v Department of Health and Mental Hyg Important; If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Ruth Ashbaugh William Charles Weidner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14 Polly Trail, Fairfield, PA 17320 Faye Ivey, daughter 20b Place of Disposition (Name of Souther) crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 1/17/2012 Carroll Crematory Winfield, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Signature of Funeral Service Licensee Name and Address of Facility Myers—Durboraw Funeral Home 210 W Main St, Emmitsburg, MD 21727 23a. Part 1. Enter the disease, or complications than caused the death. Do not enter the mode of dying, shook, or heart failure. List only one cause on each line. such as cardiac or respiratory Approximate wal Between set and Death Immediate Cause (Final Pnysician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, Examine cause. Enter Underlying burial-transif Cause (Disease or iinjury that initiated events resulting in death) Last and attending physician for use as the burial Physician/Medical equires that the death certificate be Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Pregnant at time of death Month Day Year signed by the a d be detached f P.O. E 23e. Did tobacco use contribute to the cause of death? by Rocords, 1 Yes 2 No 3 Probably 4 Unknown cate has been signal, page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate in completed filled in by the funeral director, pale performed 1 ☐ Yes 2 ☐ No Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 1 Tes 2 No ည 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Deal Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending Natural 2 No 1 Tyes Accident Investigation Suicide 6 Could not be 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: En the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse/Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature 29d. Date signed (Month, Day, Year, WJL 4

State Registrar 9

Date filed (Month, Day,

burg

of person who completed cause of death (Item 23a) (Type, Print)

32. Res

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar 03548 Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Physician/ 2012 a^{M} 2:45 Wesley 0. Warren January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Holy Cross Hospital Silver Spring If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Hours (Month, Day, Year) 099-74-8715 Director 1 → M 2 □ F 63 Aug. 31, 1948 Jamaica Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director 1 Yes 2 No MD Montgomery Silver Spring 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral USA 1111 University Blvd. W., items death 14. Race - American Indian. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) the Medical Examiner Black, White, etc. ö þ 1 Never Married 2X Married Yes 2X No Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 ☐ No Specify: If Yes, Give Year or Dates SpecifyBlack "natural" Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Nursing Home Nursing Assistant ulth and Mental Hygie 27 is marked other r traumatic event, tl Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Jeremiah N. Warren Myrtle Monteith 19a. Informant's Name/Relationship (Type, Print) 9b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1111 University Blvd₅₁West, Silver Spring, Department of Health a Important: If item 27 is any injury or other trains Pauline A. Warren/Wife MD 20902 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) n. 30, 2012 Jan 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cemetery Silver Spring, MD 22 Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, 21. Si nature of Funeral Service uhaid MD 20901 23a. Part 7. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Cardiopulmonary Arrest disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Terminal Multiple Myeloma Sequentially list conditions, in any, reading to immediate cause. Enter Underlying Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of) attending physician a I for use as the burial-Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 5 Other (specify) Month Year Pregnant at time of death been signed by the a should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Records, 1 Yes 2 No 3 Probably 4X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 \(\subseteq \text{ Yes} \quad 2 \subseteq \text{ No} \) 24a. Was an cate has autopsy performed? Yes 2 🗷 No After this certificate Division of Vital 25. Was case referred to medical filled in by the funeral director, 26. Place of Death (Check only one) Be Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) Hospital 1 Tyes 2X No ဂ္ 1 X Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completely filled in by the fune. 1X Natural 5 Pending work?
1 Yes 2 No Investigation 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Ki Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗔 only one) 29b. Signature and title of certific 29d. Date signed (Month. Dav. Year) 29c. License number D65069 January 24, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1500 Forest Glen Road, Silver Spring, MD 20910 Sirak Lemma, MD 31. Date filed (Month, Day, Year)

State

Registrar

JAN 25 2012

32. Registrar's Signature

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

		Plea	se type or			artment of H		-		jible.	
	_1	For State Registrar	State of	ı ıvıaryıarı		tificate of D		F	Reg. No. 2	112	03549
Physicia Medic		1. Decedent's Name (First, Middle DORIS	MAE		MG			2. Date of Dea	IO 2	Year 2012	
Examine	er	4a. Facility Name (if not institution, Carroll Hospita	-	ber)			Location of Death tminster		4c. Count	y of Death rrol]	
Funeral Director		5. Social Security Number 220–28–8038	6. Sex 1 □ M 2 ▼ F	7. Age (In yrs. la 79	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Apr 18	Year)	9. Birth Cou Ma 1	nplace (State or Foreign ntry) ryland
-f show led at	ctor	Usual Residence of Decedent 10a. State 10b. County Maryland Car	roll	10c. Cit	y, Town or Lo	cation	Taneyto	own			10d. Inside City Limits 1 ★ Yes 2 □ No
th the Ma 3a or 28a t be notif	Funeral Director	10e. Street and Number 47 York Street	.1011			10f. Zip Code	21787		10g. Citizen of	What Cou USA	
r items 2		11. Marital Status 1 Never Married 2 Mari	12. Was Deced	ces?	S. 13. \	Was Decedent of Hi f Yes, specify Cuba	spanic Origin? (Sp	pecify Yes or No- o Rican, etc.)	14. Ra		ican Indian, , etc.
ours after ntural", o	eted by	3 ₩ Widowed 4 □ Divorced	ied 1 Yes If Yes, Give Year or Dant's Education	9		1 Yes 2 No	Specify:		Specify 16b. Kind of B	*****	
thin 72 ho ene. than "na he Medic	Completed	(Specify only higher Elementary/Seconday (0-12)	st grade completed) College (1-	4 or 5+)	(Give life. D	kind of work done d O NOT use retired) usekeepin	luring most of wor	king		spita	
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	To Be	12 17. Father's Name (First, Middle, L Wilbur Fair			1100	<u>ascircopini</u>	18. Mother's Nan	ne (First, Middle, Angell	Maiden Surnam	ie)	
12 should aith and M 27 is mai r traumat		19a. Informant's Name/Relationsl Tony Young, So				ng Address (Street a					Code)
Page 1 and ent of Hea nt: If item ny or othe		20a. Method of Disposition 1 Burial 2 Cremation 4 Donation 5 Other (S	3 ☐ Removal from	State St	Oneten, crer	osition (Name of matory or other plac Crematory	1 4/4	Date 2/2012	20c. Location	- City or T	
permit. F Departm Importa any inju		21. Signature of Funeral Service L	icensee	SUAWON	22	2. Name and Address	s of Facility M	yers-Dur t, Taney	boraw I	uner D 21	al Home 787
Physician/		23a. Part)1. Enter the disease, or snock, or heart failure. List o Immediate Cause (Final	inly one cause on eac	ch line.					est,		Approximate Interval Between Onset and Death
Medical Examiner		disease or condition resulting in death)		or as a consequ		DAL 1	US	(100_			20 years
ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	b. —	or as a consequ							
be executed sician and burial-transit	g	that initiated events resulting in death) Last	c. Due to (i	or as a conseq	uence of):						
certificate nding phy use as the	by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outo						23d. D	ate of d eli	ivery
he death y the atter	hysicia	in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown		nant at time of		☐ Ectopic pregnand ☐ Other (specify)			M	lonth	Day Year
uires that t n signed b Ild be deta	ed by P	Part II. Other significant condition HYPERTEN		eath but not res	sulting in the (underlying cause giv	ven in Part I.	23e. Did to	-		the cause of death?
ie law requ e has beei ige 2 shou	Completed							24a. Was autop		prior to death?	topsy findings available completion of cause of
ian: The	Be C	25. Was case referred to medical examiner?					ace of Death (Che		2 A NO	T les	2 L NO
ng Physic Iter this ce Ineral dire	입	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pendir	28a. Date	Inpatient 2 of injury h, Day, Year)	ER/Outpatie 28b. Time o injury	work	4 □ Nursing F y at (?	10me 5 Resident			ify)
or Attendii fter death. iirector: Ai n by the fu	Certificate:	2 Accident Investi 3 Suicide 6 Could 4 Homicide determ	gation not be since 28e. Place	of Injury - At hong, etc. (Specif		M 1	Yes 2 No	28f. Location (S City or Tow		ber or Rui	ral Route Number,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transi completed filled in by the funeral director, page 2 should be detached for use as the burial-transi	Medical C	(Check 2 Medical I	Physician: To the bas	is of examination	n and/or inves	stigation, in my opinio	on, death occurred	at the time, date a	nd place, and d	ue to the o	cause(s) and manner stated.
To the within 2 to the C C comple	Ě	only one) 3 L Certifying 29b. Signature and title of certifie	Nurse Practioner:	ATTEN) PHYS		29c. License			29d. Date sign	ed (Month	
5		30. Name and address of person	who completed caus					STER MA			
Stat Registra		31. Date filed (Month, Day, Year)	32. R			bare) .			
			~ ~~·~ /4/5	And A desired to the Publish of the	Aug 1 254	Dr. Silver Andrews					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 03550 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 20T2 January 2240 Ρм Marjory Minor Young Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Ceci1 E1kton 539 Rock Church Road 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Age (In yrs. last birthday, **Funeral** 1 □ M 2 🗓 F Months Hours March II. 1919 Wisconsin **Director** 92 399-16-2808 Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 Tes 2 X No E1kton Maryland Ceci1 10e. Street and Number 10f. Zip Code 10q. Citizen of What Country? ò Department of Health and Mental Hygiene. Important; if item 27 is marked other than "natural", or items 23a on important; if item 27 is marked other than "natural", or items 23a on any injury or other traumatic event, the Medical Examiner must be once. Funeral 21921 United States 539 Rock Church Road Page 1 and 2 should be filed within 72 hours after death went of Health and Mental Hygiene. Iant: If item 27 is marked other than "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Black, White, etc ģ 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: Completed 3 X Widowed 4 Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) In Her Own Home Homemaker Be 18, Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ Irene O'Connell William Harley Minor 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Elizabeth Young-Brockell/Daughter 539 Rock Church Road, Elkton, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition February 1, 2012 1 Burial 2 X Cremation 3 Removal from State R. A. Ferris & Co., Inc. West Chester, PA 4 Donation 5 Other (Specify) 22. Name and Address of Facility Hicks Home for Funerals, P.A. 21. Signature of Funeral Service Licensee 103 W. Stockton Street, Elkton, MD 21921 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final WITH METS TO ADRENAL COLON Pnysician/ CANLER disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to for as a consequence of, been signed by the attending physician and should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be-24 hours after death.
 Funeral Director: After this certificate has been signed by the attending physicis Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Other (specify) Pregnant at time of death 4 ☐ Pregnant a 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy After this certificate has funeral director, page 2 performe performed? 1 Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 4 Nursing Home 5 Residence 6 Nother (Specify) Residence Hospital: 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ၉ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 2 Accident injury work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation within 24 hours after death

To the Funeral Director: A
completed filled in by the 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one

SM

State Registrar

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHAHNAWAZ KITAN MD
2533 AUGUSTINE HERMAN ITWY, SUITEA, CHESAPEAKE CITY, MD 21915 32. Registrar Signature FEB 0 8

D0062190

29d. Date signed (Month, Day, Year)

2012

12-00971 Robert Jeffrey Ad	ler	Please Ty			Black								.egibl	le.			
		- For State Registrar				ertifica					, ,		Reg. No	. 20		2 (355
Physician	1/	Decedent's Name (First, Mic	die,Last)								2.	Date of D	eath				of Death
Ma∕¶ical Examin		Robert Jeffr										Month Februar	y 1, 20	12		203	8 hrs
, ,	ı	4a. Facility Name (if not instituted I-70, 1/4 mile east of		reet and nu	mber)		44	. City, Tow Frederic		ocation o	f Death			c. County of Frederic			
Funeral	T	5. Social Security Number	6. Sex		7. Age (In yı	rs. last birt	hday)	If Under		If Unde		8. Date of	Birth (MA	M/DD/YYYY	9. Birt Foreig		state or
Director		063-48-9030	1 <u>X</u> M	2_F		5	6 Yrs.	Months	Days	Hours	Min.	July	22,	1955	Co	^{intry} Ne	w Yorl
Á	-	Usual Residence of Decedent 10a. State 10b. Count	у		10c. 0	City, Town	or Locatio	n				-				10d. Ins	ide City Limit
.	اح	Maryland How	ard			Co	lumbi	.a								1 🔲	∕es 2 💢 N
larylar 28a-f	Director	10e. Street and Number	-					10f. Zip Co	ode				10g. C	tizen of Wh	at Cour	itry?	
th the Maryland 23a or 28a-f show notified at once.	֓֞֓֞֞֓֓֓֞֓֓֡֓֞֓֓֡֓֡֓֡֡֓֡֡֞֡֓֡֡֡֡֡֡֡֡֡	9543 Sea Shado	W					2	2104	6				USA	A		
h with		11. Marital Status		2. Was Dec Armed Fo	edent Ever in	n U.S.	13. Was	Decedent	of Hispa	anic Orig	in? (Spec	ify Yes or	No-	14. Race White		can India	n, Black,
	/ Funeral	1 Never Married 2 3 Widowed 4 D	1	Yes Yes, Give Yee	2 X N	0		res 2 X				,		Specify:	ĵ₩h	ite	
ours a	9	15. Decedent's Education (Sp	10	Dates:		i) 16a. I	Decedent's						16b.	Kind of Bus	siness/I	ndustry	
72 h	Completed	Elementary/Secondary (0-12	2)	College (1	-4 or 5+)		during mos		ig lite. D	ONOI	use retired)					
Within within iene.	틹			5+			Analy	st								ace	Center
filed of the other	2 8 8	17. Father's Name (First, Middl George J. Adl							18		s Name (F zendo			n Surname)			
212 uld be Ments mark	<u>-</u>	19a. Informant's Name/Relation		, Print)		198	o. Mailing /	Address (Street a					City or Town	n, State	Zip Cod	e)
MD 21215-0036 d 2 should be filed within 7 lith and Mental Hygiens n 27 is marked other than 10 matic event, the Medica	7	Kenneth J. Ad	ler,	Broth	er	4:	195 (araml	oola	Cir	cle	North	n Coo	conut	Cre	ek,	FL3306
re, I and I and I and I ten		20a. Method of Disposition 1 ☐ Burial 2 ∑ Cremati	2	Dames al far		Ob. Place o	of Dispositi		of ceme	itery,		ate	20c	. Location -	City or	Town, St	ate
Pages ient of int. I		4 Donation 5 Other		Removal III		letro	Crem	atory	/ In	ic.	02/0	9/12	Ва	altimo	ore,	Mar	yland
Baltimore, MD 21215-000; pemit. Pages I and 2 should be filed with Department of Health and Mental Hygiene. Important: If Item 27 is marked other injury or other traumatic event, the Mediuly or other traumatic event, the Medium 2018 in the M	Ī	21. Signature of Funeral Service	Thom	as Gre	egor	22, Na Cre	me and Ad	dress o	Facility	tv 0	f Mar	-vlai	nd Inc	`.			
	_	23a. Part I. Enter the disease,	27-	yo-		ath Da an	299	Free	leri	ck F	Road	Balti	more	e, Mar	yla	nd 2	21228 ximate Interv
Physician Medical		failure. List only one caus	e on each	line.		atn. Do no	it enter the	mode of d	ıyıng, su	ich as ca	irdiac or re	spiratory	errest, si	lock, of field	ii C		en Onset an Death
≛xaminer		Immediate Cause (Final diseas or condition resulting in death)		ıltiple İnju	consequenc	e of):			_			_		_		-	
	1	Sequentially list conditions,	b			,-											
		if any, leading to immediate cause. Enter Underlying Caus	e	e to (or as a	consequenc	e of):											
7.	Ēŀ	(Disease or injury that initiated events resulting in death) Last	C.	e to (or as a	consequenc	e of):				-				***			
V B BB 7	≅ ŀ-		d													<u> </u>	
be exc sician urial		UNPENDED	A	MENDED						_							
376(ficate g phy s the b	2	IF FEMALE: 3b. Was decedent pregnant in	the	23c. If yes, o	utcome of p	100	□ Ento	I death	3	Ectonic	pregnanc	v	2	3d. Date of Month		ay	Year
Box 68760, e death certificate be the attending physic ed for use as the buri		past 12 months?			ant at time of	f death 5	=	(Specify	_	Jestopio	p g	_				-,	
Bo e deat the at the at	≧L	1 Yes 2 No 9 U		9 Unkno													
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the an infector After this certificate has been signed by led in by the funeral director, page 2 should be detacted.	y r	Part II. Other significant cond	itions co	ntributing to	death but no	ot resulting	in the un	derlying ca	use give	en in Par	t I.			o use contri ✓ No 3			
duires	9											24a. W					dings availab
Orc law re has be 2 shor	Сошріете	 										au	topsy	р			n of cause of
Rec The licate	5											1 ✔ Ye			√ Ye	s	2 No
ician:	8	25. Was case referred to medic examiner?		oital: 1	apatient 2		utpatient		-		Check onl	<u> </u>	Pacie	tence 6 🔻	Other	Scana	
ing Physi ing Physi After this uneral dir	라	1 Yes 2 No 27. Manner of Death		28a. Date	of Injury		Time of Inju			at Work?				jury occurre		Julia	
OD C		1 Natural 5 Pe	nding	Feb 1, 2	Day,Year) J12	2020	hrs	1	Yes	s 2 🗸	_{No} Sι	ıbject d	river in	auto aut	o coll	sion	
r Atte ter der irecto	2		estigation uld not be	28e. Place	of Injury - A	At home, fa	rm, street,	factory, of	fice buil	Iding, etc	. 28			and Number	r or Ru	al Route	Number, Cit
Difful o	Certification:	4 Homicide	ermined	(Specify)	Major R	oad / Hi	ghway				1-7	0, 1/4 m	n, State) nile east	of Rt. 75,	Freder	ick, MD	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be excluding 24 hours after death within 24 hours after death. To the Funcar Director. After this certificate has been signed by the attending physician. completely filled in by the funeral director, page 2 should be detached for use as the burial.	g				of my know												3)
To T with To com		29b. Signature and title of certi	an	d manner st					icense r					. Date signe			
		Will !	I am	11.11	118			0	C.M.	.E.				bruary 2			
20		30. Name and address of person											055				
0		Melissa Brassell, MD	Assi	stant Med	dical Exar	miner	SOO W.	Baltimo	re Str	eet, Ba	utimore	, INIU 21	223				

State 31. Date filed (Month, Day, Year)

OCME

32. Registrar's Signature

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 03552 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Leonard George 2012 11:15 A.M February Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner **Annapolis** Anne Arundel Anne Arundel Medical Center If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Social Security Number **Funeral** Months 212-12-6133 90 **Director** 1 X M 2 □ F Jan 21, 1922 Maryland Yrs Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location must be notified at Director 1 Yes 2 X No Maryland Anne Arundel Deale 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 0 23a Funeral 20751 U. S. A. 6067 Drum Point Road items 2 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status 12. Was Decedent Ever in U.S. the Medical Examiner Armed Forces?

1 X Yes 2 No
If Yes, Give Black, White, etc. ō þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 🛣 No Specify: White "natural", 3 X Widowed 4 Divorced Completed Year or Dates. 1942-45 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Commercia1 and Mental Hygiene. is marked other than College (1-4 or 5+) Elementary/Secondary (0-12) Food Service 12 Estimator Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Margaret Gustaitis Belas George 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health an Important: If item 27 is any injury or other trau Beverly M. Eastman/Daughter 14112 Westholme Court, Bowie, Maryland 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 \square Burial 2 X Cremation 3 \square Removal from State 4 \square Donation 5 \square Other (Specify) cemetery, crematory or other place) 2/10/2012 Glen Burnie, Maryland Atlantic Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert E. Evans Funeral Home, 20715 16000 Annapolis Road, Bowie, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ resulting in death) Medical Due to (or as a consequence of Examiner 19 duxs Sequentially list conditions, if any, leading to immediate cause. Enter conditions Cause (Disease or injury Due to (or as a consequence of): physician and that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 the use as 1 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No for Year Month Day Pregnant at time of death be detached 1 ☐ Yes 2 ☐ Unknown g 🗌 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed? the Hospital or Attending Physician: The I hin 24 hours after death. the Funeral Director: After this certificate h 1 ☐ Yes 2 ☐ No in by the funeral director, 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ 1 Impatient 2 I ER/Outpatient 3 I DOA 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital or within 24 hours aft To the Funeral Discompletely filled in Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

State

54

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

12-00591 Martha Blackwell		or Print in Black te of Maryland / De		f Health and Me		egible.	2 0355
	Registrar 1. Decedent's Name (First, Middle,			Death	2. Date of D	Reg. No.	3. Time of Death
Medical Examiner		kwell			Month January	Day Year 21, 2012	1400 hrs
	4a. Facility Name (if not institution,	give street and number)		4b. City, Town, or Location	n of Death	4c. County of Deat	1
	Mercy Medical Center 5. Social Security Number 6	Say 17 Age (let)	rs. last birthday)	Baltimore If Under 1 Year If Un	nder 24Hrs. 8. Date of	N/A Birth (MM/DD/YYYY) 9. Bir	tholece (State or
Funeral Director	220-36-7448	Sex 7. Age (In y	73 _{Yrs}	Months Days Hou	na Adia	Foreig	
ady	Usual Residence of Decedent 10a, State 10b, County	10c. (City, Town or Locat	ion			10d. Inside City Limits
	MD N/A	Ва	altimore	2			1 X Yes 2 No
the Maryland in or 28a-f sh infed at once	10e. Street and Number			10f. Zip Code		10g. Citizen of What Cou	ntry?
3a or otified	1033 W. Lomba	rd Street		21223		USA	
or items 23	11. Marital Status 1 Never Married 2 Marr	12. Was Decedent Ever i		is Decedent of Hispanic O es, specify Cuban, Mexic		No- 14. Race - Amer White, etc.	ican Indian, Black,
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 33a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	3 Widowed 4 Divor	1 Yes 2 X N ced if Yas, Give Year or Dates:	1	the contract of		Specify: Bla	
"natu	15. Decedent's Education (Specif Elementary/Secondary (0-12)	y only highest grade completed College (1-4 or 5+)		it's Usual Occupation (Giv ost of working life. DO NO		16b. Kind of Business/ Baltimor	•
5-0036 ed within 72 hour 15 yearen. other than "natu the Medical Exar Completed	12th	N/A	Teach	ner's Aid		Public S	
5-0 led wi Hygier of the M	17. Father's Name (First, Middle, L				er's Name (First, Middle		
121 d be fil fental l narked event,	Matthew Loc 19a. Informant's Name/Relationship	the state of the s	10h Mailine		lyn M. De	W lumber, City or Town, State	Zin Codo)
AD 21 2 should a and Mer 27 is man matic ev	Oscar Sanders			·		Baltimore	
G, N I and 3 Health item 3	20a. Method of Disposition	2	Ob. Place of Dispos	ition (Name of cemetery,	Date	20c. Location - City or	Town, State
MOF Pages ent of nat: If	1 Burial 2 Cremation 4 Donation 5 Other Spec	3 Removal from State	king Men	nerplace) Norial Pk.	2/2/2012	Randalls	town, MD
Baltimore, MD 21215-0036 bernit. Pages I and 3 should be filed within 7 Department of Health and Mental Hygiene. Important: Witem 27 is marked other than highry or other traumatic event, the Medical To Be Compile	21. Signature of Funeral Service Li					/H East 11	
	23a Part I Enter the disease or or	omplications that caused the de				, MD 21202	Approximate Interval
Physician /Medical	23a. Part I. Enter the disease, or co failure. List only one cause or	each line. Hyperten	sive Caro	liovascular	Disease con	plicated by	Between Onset and Death
<i>E</i> xaminer	Immediate Cause (Final disease or condition resulting in death)	a right arm fr Due to (or as a consequence					
	Sequentially list conditions,	b					
t xaminer	if any, loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	Due to (or as a consequent c.	Re-Gr):				
ted nasit	events resulting in death) Last	Due to (or as a consequence	ce of):				
execular and an and al - tra	X UNPENDED	d	.11,27,28	Ba−f,per me,	g925 3-19-	l2 sm	
Box 68760, to death certificate by the attending physic led for use as the bur thy sician/Mec	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of p		tal death 3 Ecto	pic pregnancy	23d. Date of deliver Month	y Day Year
x 68 h certi tendin use as	past 12 months?	4 Pregnant at time of	of death	tal death 3Ecto her (Specify)	pic pregnancy	Month	Jay Teal
Bo ne deat the at red for	1 Yes 2 No 9 Unkno	9 OHNIOWH			100 0		
P.O.	Part II. Other significant condition History of cen					d tobacco use contribute to √es 2 ✔ No 3 ☐ Pro	
ds, een sig ould be				Respirator	24a. Wa		atopsy findings available
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buriedical Certification: To Be Completed by Physician/Med	failure and D	labetes Mellit	us		per	topsy prior to death? s 2 No 1 V	completion of cause of
tal Rician: 1 certific ector, p	25. Was case referred to medical examiner?			101	th (Check only one)		
Physic r this cal dire	1 ✓ Yes 2 No		✓ ER/Outpatient				r:
on of ading Pl th.: After e funeral	27. Manner of Death 1 Natural 5 Pendin	28a. Date of Injury (Month, Day,Year)	28b. Time of I	4□ Van 05	_ •	e how injury occurred	
risio Atter er deal rector by the	2 Accident Investi	gation 28e Place of Injury	unknowi At home, farm, stree	et, factory, office building,		n (Street and Number or Ru , State) 2700 Nort	ral Route Number, City
Division or spital or Attending nours after death. Tilled in by the funer certification:	3 Suicide 6 Could determ	not be	nursing	_	St.	State)2700 Nort Baltimore,MI	n Unarles'
Division Divisi	29a. Certifier 1 Certifying Phy	sician: To the best of my know					
To the Ho within 24 I to the Fu completely	one) 2 Medical Exami	ner:On the basis of examination and manner stated.	on and/or investiga	tion, in my opinion, death	occurred at the time, da	ite and place, and due to th	ne cause(s)

State Registrar

Assistant Medical Examiner 32. Registrar's Signature

900 W. Baltimore Street, Baltimore, MD 21223 parke

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

January 22, 2012

30. Name and address of person who completed cause of death (Item 23a)

29b. Signature and title of certifier

Donna M. Vincenti, MD

31. Date file (B) 09 2012

12-01089 Anthony Burrell Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 03554

			e of Death	Reg. No.	
Physicia dical Examin	n/ er	Registrar 1. Decedent's Name (First, Middle,Last) Anthony	Burrell	2. Date of Death Month Day Year February 6, 2012 3. Time of Death 0640 hrs	n
		4a. Facility Name (if not institution, give street and number) 9104 Thistledown Road	4b. City, Town, or Location of Death Owings Mills	Baltimore County	
Funeral Director	2	5. Social Security Number 6. Sex 7. Age (In yrs. last birtho	Ay) If Under 1 Year If Under 24Hrs Months Days Hours Min.	Foreign	
nd how any ce.	Ī	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or MD Baltimore Ov	Location Vings Mills	10d. Inside City 1	- 4
ith the Maryland 23a or 28a-f show notified at once.		10e. Street and Number 9104 Thistledown Road Apt 475	10f. Zip Code 21117	10g. Citizen of What Country? U • S • A •	
or items	-	11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year	Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto Yes 2 \ No specify:	pecify Yes or No-Rican, etc.) 14. Race - American Indian, Black White, etc. Specify: Black	ς,
7	leted by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	acedent's Usual Occupation (Give kind of varing most of working life. DO NOT use reti	work done red) nician Red Bag Solution	on
21215-0036 wild be filed within 72 Mental Hygiene. marked other than to event, the Medical	o.	12th grade na Med 17. Father's Name (First, Middle, Last) Samuel Burrell	18.Mother's Name	ine Watkins	
MD 21215 10 2 should be fill alth and Mental H m 27 is marked numatic event, i	اق	19a. Informant's Name/Relationship (Type, Print) Sharon Burrell-Wife 9	104 Thistledown	110 211	1 ⁷ 11
Baltimore, MD 2121 permit. Pages 1 and 2 should be fi Department of Health and Mental Important: If item 27 is marked iojury or other traumatic event,		1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify: King	Disposition (Name of cemetery, y or other place) Memorial Park 2/	Date 20c. Location - City or Town, State 11/2012 Woodlawn, Md	
Physician Physician	-11	Signatur of Funeral Service Licensee 23a. Part J. Enter the disease, or complications that coused the death. Do not	22. Name and Address of Facility March F/H West 4300 Wabash Ave enter the mode of dying, such as cardiac of	Baltimore, Md 21215 or respiratory arrest, shock, or heart Approximate In Between Ons	Interval
/Medical £xaminer	1	fail e. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Atherosclerotic Cardiovascula Due to (or as a consequence of):		Death	
	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last			
760, cate be executed physician and the burial - transit	Medical E	d. UNPENDED AMENDED			
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physiciao: The law requires that the death certificate be executed within 24 hours after death. To the Fuoeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transil.	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 4 Pregnant at time of death 5	Fetal death 3 Ectopic pregn Other (Specify)	23d. Date of delivery ancy Month Day Ye	ear
P.O. Be es that the de signed by the be detached f	<u>a</u>	Part II. Other significant conditions contributing to death but not resulting	in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of dea 1 Yes 2 No 3 Probably 4 V Unk	known
Division of Vital Records, P.O. Lat or Atteoding Physiciae: The law requires that the safter death. al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detactled.	Completed			24a. Was an autopsy findings av prior to completion of cau death? 1 ✓ Yes 2 No 2 Yes 2 1	use of
ital Reciding The Interpreted the Interpreted to Italian Interpreted to Italian Interpreted Interprete	Be C	25. Was case referred to medical	26.Place of Death (Check		
Vita hysicia this co	TO B	1 Yes 2 No		ing Home 5 Residence 6 Other: Scene	
on of coding Physath. or: After the funeral	ition: T	1 Valural 5 Pending (Month, Day, Year)	ime of Injury 28c. Injury at Work?	28d. Describe how injury occurred	
Division To the Hospital or Atteod within 24 hours after death. To the Fuoeral Director: completely filled in by the !	Certification:	3 Suicide 6 Could not be determined (Specify)	m, street, factory, office building, etc.	26f. Location (Street and Number or Rural Route Numb or Town, State)	er, City
To the Hospital within 24 hours: To the Fuoeral completely filled	Medical (29a. Certifier 1 Certifying Physician: To the best of my knowledge, dea (Check only one) 2 Medical Examiner: On the basis of examination and/or in and manner stated,	vestigation, in my opinion, death occurred	at the time, date and place, and due to the cause(s)	
H » H »	Me	29b. Signature and title of certifier	29c. License number O.C.M.E.	29d. Date signed (Month, Day, Year) February 6, 2012	
	1		900 W. Baltimore Street, Balti	more, MD 21223	
St	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature	į.		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1	For State State Registrar	e of Maryland / D	epartment of H Certificate of D		lental Hygier Reg.	21112	03555
	Physicia		Decedent's Name (First, Middle, Last) Edna	Catherine	Bradford		2. Date of Death Month February		3. Time of Death 7:57 A M
	Medic Examin		4a. Facility Name (if not institution, give street and		4b. City, Town, or			4c. County of Death	
	Funeral		Gilchrist Center 5. Social Security Number 6. Sex	7. Age (In yrs. last birth	Towson	If Under 24 Hrs.	8. Date of Birth	Balti 9. Birthp	lace (State or Foreign
H	Director		215-16-1215 1□M2	90 Y	rs. Months Days	Hours Min.	March 18,	1921 Mar	yland
	and show dat	for	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town	or Location			1	0d. Inside City Limits
	e Mary 28a-f notifie	Sirec	MD Baltimore		Caton	sville_	1.0	Citizen of What Coun	1 Yes 2 XNo
	with th 23a o ust be	Funeral Director	1304 McCurley Avenue	9		1228	109.	USA	uyr
ထွ	should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at		Arm	Decedent Ever in U.S. ed Forces? Yes 2 X No s, Give	13. Was Decedent of His If Yes, specify Cubar	, Mexican, Puerto	cify Yes or No- Rican, etc.)	14. Race - Americ Black, White, e	etc.
Baltimore, Maryland 21215-0036	ours af atural" cal Exa	Completed by	3 X Widowed 4 ☐ Divorced Year 15. Decedent's Education	or Dates.	1 ☐ Yes 2 🔀 No Decedent's Usual Occupa		161	Specify: Whit	
215	iin 72 h ie. han "na • Medid	ompl	(Specify only highest grade comp Elementary/Seconday (0-12) Colle	leted)	(Give kind of work done du life. DO NOT use retired)		ng		
d 21	ed with Hygien other ti ent, the	Be C	12 17. Father's Name (First, Middle, Last)		Homemaker	18. Mother's Name	(First, Middle, Maio	Own Ho	me
ylan	ld be fil Mental arked o	욘	Arthur E.	Rothauge		Eul	, ,	Waterworth	
Man	is an all		19a. Informant's Name/Relationship (Type, Print)		Mailing Address (Street a				
re,	t of Health If item 27 or other tra		Barbara Clark, niece 20a. Method of Disposition	20b. Place of	53 Carroll M Disposition (Name of y, crematory or other place			win, MD 2 Location - City or To	
time	Pag neni ant: ant:		1 ☐ Burial 2 🛣 Cremation 3 ☐ Remova 4 ☐ Donation 5 ☐ Other (Specify)	Metro	Crematory,	Inc. 02/0		Baltimore,	
Ba	permit. Departr Import. any inji		21. Signature of Funeral Service Licensee Ger	orge MacNabb	22. Name and Address 299 Frede			ociety of imore, MD	MD, Inc. 21228
1	Hıysician/ Medical		23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one cause Immediate Cause (Final disease or condition resulting in death)	on each line. Sheke	ot enter the mode of dying				Approximate Interval Between Onset and Death
	Examiner			ue to (or as a consequence of	1):				
0.4	ed ssit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Uisease or iinjury	ue to (or as a consequence o	f):				
36	execute an and rial-tran	l Exa	that initiated events C. ——	ue to (or as a consequence o	f):				
09/	physici the bu	edical	d						
Box 687	To the Hospital or Attending Physician: The law requires that the death certificate be executed within £4 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and To the Funeral Director, page 2 should be detached for use as the burial-transit completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Me	in the past 12 months?	s, outcome of pregnancy Live Birth 2 Fetal death Pregnant at time of death Unknown	3 Ectopic pregnancy 5 Other (specify)	у		23d. Date of deliver	ery Day Year
Records, P.O.	es that th signed by I be detac	ğ	Part II. Other significant conditions contributing	g to death but not resulting in	n the underlying cause giv	en in Part I.	23e. Did tobac	co use contribute to the	ne cause of death?
cords	aw requii as been 2 should	Completed					24a. Was an autopsy	prior to co	psy findings available mpletion of cause of
Re	n: The l ficate h or, page		25. Was case referred to medical		26 Ple	ace of Death (Checi	performed	death? No 1 ☐ Yes	2 🗆 No
Vita	nysicial iis certi directo	To Be	examiner? 1 Yes 2 No Hospital:	1 Inpatient 2 ER/Out	_ Othe			e 6 Other (Specify	nospice
n of	ding PI th. After th funeral		27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	Date of injury (Month, Day, Year) 28b. T	njury work'	at	28d. Describe how i		
Division of Vital	or Atten after deal Director: in by the	Certificate:	2 Quicido 6 Could not be	Place of Injury - At home, far building, etc. (Specify)			28f. Location (Stree City or Town, S	t and Number or Rura tate)	Route Number,
	Hospita 24 hours Funeral leted filled	ledical	29a. Certifier (Check conly one) 3 Certifying Physician: To	the best of my knowledge, on the basis of examination and/or	death occured at the time, r investigation, in my opinio	date and place, ar	d due to the cause(s the time, date and p	s) and manner as state lace, and due to the ca use(s) and manner as si	ed. use(s) and manner stated. ated.
	To the Comp	Σ	29b. Signature and title of certifier		29c, License	number	29d	Date signed (Month,	Day, Year)
	10		30. Name and address of person who complete	he basis of examination and/or oner: To the best of my knowled to the	Type, Print)	12000	et on	son m	2
	Sta	te.	FEB 0 97 2012 Com	32. Rejistrar's jonates	101 10,00		7 70-1		
	Registr		LED A STATE COMME	4. 17					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Florine Louise Byrd 3:50 PM 2/3/201 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Future Care Baltimore . Social Security Number 8. Date of Birth (Month, Day, Year) 7/22/1934 If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 216-32-5741 **Director** 1 M 2 X F 77 Yrs Alabama 28a-f shov 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director MD N/A 1 X Yes 2 No Baltimore 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2700 N. Charles St. 21218 USA "natural", or items 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Completed by Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black 3 X Widowed 4 Divorced Year or Dates injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Laborer 12th Various Jobs Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Johnnie Stewart Julie Stamps 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alyanda Garnett-Daughter 629 E. <u>36th St. Baltimore, MD 21218</u> 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Garden of Faith 2/11/2012 | Baltimore, MD Donation 5 Other (Specify) 22. Name and Address of Facility March F/H East 1101 E. 21. Signature of Fune al Service Licensee Grand. Much. North Ave. Baltimore, MD 21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of Examir Hospital or Attending Physician: The law requires that the death certificate be executed and -tran that initiated events Due to (or as a consequence of): resulting in death) Last physician a s the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Oster Disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? constative Heart 2 🗌 No Yes 2 W 25. Was case referre to medical Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes Other: ဂ္ဂ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No Natural 5 Pending Accident Investigation Suicide 6 Could not be within 24 hours after dec

To the Funeral Director

completely filled in by th 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) WARN D 31464 2/3/12

State Registrar FEB 0 9 2012 (Month, Day, Year) 32. Registrar's Signature

HOAIIS A. HASHMI

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD & 21 N. ENTAW ST Shitz 30 & BALTIMORE MD 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death February 2012 Physician/ 4:00 P M Marjorie Althea Barnes Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Silver Spring Holy Cross Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Director 577-80-0378 1 □ M 2 💢 F 55 Jun 21, 1956 Washington DC ms 23a or 28a-f show must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State with the Maryland Director 1 ∏ Yes 2 X No Silver Spring MD Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20904 UŠA Funeral 14120 Castle Blvd. #101 items death 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status ral", or iten Examiner Armed Forces? Black, White, etc. ģ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2X No Specify. Specify: Black If Yes Give 3 Widowed 4 Divorced Completed Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) the Transportation Bus Driver ed other Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) f Health and Mental Hitem 27 is marked ot မ Alfred Jessie Ella May Dew Barnes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shawnvelle McNeil/daughter 14120 Canterbury Lane Rockville, MD 20853 item 2 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Date permit. Page 1 a
Department of H
Important: If ite
any injury or ot range of the place)
Final Journey Crematory 02/07/12 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Going Home Cremation Service P.O.Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Anoxic Encephalopathy Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Respiratory Arrest Sequentially list conditions, cause. Enter Underlying Examir Hypoglycemia Cause (Disease or injury the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last physiciar Completed by Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: use a 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 X No Month Year Day for Pregnant at time of death the g Unknown g Unknown signed by t Id be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown **ESRD** peen 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of death? cate has by page 2 s performed? 1 ☐ Yes 2 ☐ No Yes 2 No 26. Place of Death (Check only one) 25. Was case referred to medica Be examiner? 1 ☐ Yes 2 🛚 No Hospital Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) မှ 1X Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred work? 1 X Natural iniury 5 Pending 2 🗆 No 2 Accident Investigation within 24 hours after death

To the Funeral Director: / Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Xcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 only one 29d. Date signed (Month, Day, Year) 29b. Signature and title 29c. License numbe D67589 20/2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State Registrar Harold V. Lawson

32. Reg

M.D. 1500_Forest Glen Rd. Silver Spring, MD 20910

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar 03558 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Henson Braddock February 2012 11:58 A^M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Casey House Rockville Montgomery If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Massachusetts 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Day, Year) 5 - 1920 Days Hours Min Months Director 049-16-4900 1 🗆 M 2 🗶 F 92 Jan 6, Yrs Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits with the Maryland notified at Director 1 ☐ Yes 2X No MA Barnstaple Orleans 9 10e. Street and Number 10f. Zip Code ms 23a or 10g. Citizen of What Country? Funeral 29 Hensons Way 02653 USA filed within 72 hours after death items 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Black, White, etc. ò 1 V Yes 2 No If Yes, Give Year or Dates. 1942–45 þ 1 Never Married 2 Married Maryland 21215-0036 Specify: White 1 ☐ Yes 2X No Specify. "natural", 3 X Widowed 4 Divorced Completed Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the Librarian Municipal Government 5+ event, 1 Be permit. Page 1 and 2 should be file.
Department of Health and Mental Helmportant: If item 27 is meany injury or other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ပ Paul Palmer Henson Theda Parker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sarah Braddock Fisher/daughter 700 Erie Avenue Takoma Park, MD 20912 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2X Cremation 3 Removal from State Final Journey Crematory 02/09/12 Woodbine, MD 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Ischemic Cardiomyopathy disease or condition Medical resulting in death) Examiner Atrial Fibrillation Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examir physician and s the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical certificate be P.O. Box 68760 as nding (IF FEMALE: use 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Live Birth 2 Live as as Pregnant at time of death jo Month Day Year signed by the at d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Chronic Obstructive Pulmonary Disease Division of Vital Records, 1 Yes 2 No 3 Probably 4 Vnknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? of or Attending Physician: The safter death.

Director: After this certificate 1 🗌 Yes 2 🗌 No 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6X Other (Specify) hospice 1 Yes 2 X No ပ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 🔀 Natural 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending work?
1 Yes 2 No 2 Accident Investigation 6 Could not be 3 Suicide
4 Homicide Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital c within 24 hours at To the Funeral D Medical 🔼 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number D60634 February 4, 2012

W DHMH 17 Rev 06-2011

State Registrar 6001 Muncaster Mill Rd. Rockville, MD 20855

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Bindu Joseph, M.D.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Lehruar Physician/ Medical Eacility Name (if not institution, give street and number) 4b. City, Town, or Location of Death County of Death **Examiner** If Und Social Security Number 8. Date of Birth (Month, Day, Dec 25. 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** New York 1X M 2 D F 081-16-1102 90 Director 1921 Usual Residence of Decedent ms 23a or 28a-f show must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. and If if item 27 is markeder than "natural", or items 23a or 28a-f sho ant: If item 27 is marked than "natural", or items 52a or 28a-f sho ury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Frederick Adamstown 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3363 Upland Court 21710 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1944–46 1 🗌 Yes 2 🎇 No Specify.White 3X Widowed 4 □ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Defense Electronics Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Samuel Buyer Edith Selma Michael 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan Patterson Buyer/daughter 11805 Charen Lane Potomac, MD 20854 permit. Page 1 and 2:
Department of Health
Important: If item 27
any injury or other tr 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crematory 02/07/12 Woodbine, MD Signatur of Funeral Service Licensee Cremation Service P.O. Box 784 Heckrotte, P.A. cLarksville, MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death Immediate Cause (Final Physician/ Medical resulting in death) to (or as a consequence of) Examiner Sequentially list conditions, Due to (or as a sonsequence of). cause. Enter Underlying Cause (Disease or iinjury that initiated events Exam attending physician and for use as the burial-trar Due to (or as a consequence of) resulting in death) Last Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 D Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months'
1 Yes 2 No 3 Ectopic pregnancy 5 Other (specify) Month Pregnant at time of death ed by the detached 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ate has been signed page 2 should be det 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? performe Yes 2 No Yes within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, I Certificate: To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury Natural 5 Pending 1 Tyes Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check only one) Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signat 29d. Date signed (Month, Day, Year) reb 710 completed cause of death (Item 23a) (Type, Print) Obi State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Dav Year Brocat 12 05 AM osephino Seventh 2014 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A Baltimon 1400 If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Maryland 7. Age (In yrs. last birthday, 8. Date of Birth **Funeral** Days 12/16/1942 1 M 2 X F 214 40 0190 69 Director Usual Residence of Decedent 28a-f show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director Baltimore Maryland Anne Arundel 1 Yes 2 X No 10e. Street and Numbe ö 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 624 Surfside Avenue 21225 U.S. death 1 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 0 1 Never Married 2 X Married ģ Page 1 and 2 should be filed within 72 hours after Saltimore, Maryland 21215-0036 1 Yes 2 No Specify: "natural", Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. marked other than Elementary/Seconday (0-12) 12th College (1-4 or 5+) Housewife Own Home Be Le snould be filed copartment of Health and Mental Hy, important: If item 27 is marked other any injury or other the contractions. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Joseph Rockko Mary Youngbar 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) George Brocato / Husband 624 Surfside Avenue Baltimore, Maryland 21225 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State Glen Haven Mem. Park 02/10/2012 Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gonce Funeral Service, F.A.
4001 Ritchie Highway Baltimore, Maryland 21225 Signature of Funeral Service Licensee 23a. Part 1. Enter the disease for complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ Respirato disease or condition resulting in death) Medical Due to (or as a consequence **Examiner** Sequentially list conditions, cause. Enter Underlying Cause (Disease or iinjury burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last ttending physician Physician/Medical Box 68760 as the l IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery ☐ Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Pregnant at time of death 5 Other (specify) signed by the 9 Unknown Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 2 🗌 No 3 ☐ Probably 4 ☐ Unknown Completed 1 Tyes certificate has been 24a. Was an 24b. Were autopsy findings available the Hospital or Attending Physician: The law r hin 24 hours after death. the Funeral Director: After this certificate has b prior to completion of cause of death? autopsy 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No မ 1 🗌 Yes Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manne of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred injury Natural 5 Pending Accident Investigation within 24 hours after death To the Funeral Director: / completed filled in by the f 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie

Registrar

State

RE5-001

300/ south

hanour ST Maltime AD 2122

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Da February Day Physician/ 6:20 A.M Richard R. Brophy, Jr. 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death Examiner Chever1v Howard Prince George Hospital 9. Birthplace (State or Foreign Country) Manual and If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 10/30/1944 7. Age (In vrs. last birthday) **Funeral** Months Hours 217 40 3908 Marvland 67 Director Usual Residence of Decedent or 28a-f show 10a, State 10b County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland ir than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director Landover Maryland Prince George 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10a, Citizen of What Country? Funeral U.S. 20785 7220 Tamo Court 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11 Marital Status Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: White If Yes, Give Year or Dates. Viet Nam Specify: Completed 3 → Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry al Hygiene. Elementary/Seconday (0-12) 12th College (1-4 or 5+) Computer Technician American Satelite Corp permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, I Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 0 Evelyn H. Schait Richard R. Brophy, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5918 Charles Street Gwynn Oak, Maryland 21207 Richard Brophy III / son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 XBurial 2 Cremation 3 Removal from State Marriottsville, MD. 02/06/2012 4 ☐ Donation 5 ☐ Other (Specify) Crestlawn Cemetery Gonce Funeral Service, P.A. ghway Baltimore, Maryland 21225 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 4001 Ritchie Highway come 23a. Part 1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examine in any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events the burial-tran the Hospital or Attending Physician: The law requires that the death certificate be exect Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as 1 IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day for Pregnant at time of death Yes 2 No the be detached 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? but not resulting in the underlying cause given in Part I. Part II. Other significant conditions contributing to de Completed by 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 1 TYes page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy has 2 **N**o certificate ! 1 Tyes 26. Place of Death (Check only one) within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to nedical Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 🗆 No 1 Impatient 2 ER/Outpatient 3 DOA မ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending work 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide Medical Scritifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

3× \

Registrar

MI

Print)

ress of person who completed cause of death (Item 23a) (Type

a

2012

enruar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) February 201^{Year} Physician/ PM Benedek 6:00 Stephen Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5511 Muncaster Mill Road Montgomery Rockville 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 577-54-8726 1 **X** M 2 □ F **Director** April 27, 1921 90 Hungary Yrs. Usual Residence of Deceden 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a. State Director ir than "natural", or items 23a or 28a-f s the Medical Examiner must be notified 1 Yes 2 X No Rockville Maryland | Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20855 United States 5511 Muncaster Mill Road Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Black, White, etc 1 Never Married 2 X Married ģ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes, Give Year or Dates Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. College (1-4 or 5+) Elementary/Secondary (0-12) Physical Education Teacher University Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) should be file and Mental F is marked of Hedwig Victoria Zaforek Stephen Benedek traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. 5511 Muncaster Mill Road, Rockville, Maryland 20855 Elizabeth Benedek /Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition Montgomery Crematorium, Inc. February 1 Burial 2 X Cremation 3 Removal from State Bethesda, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 10, 2012 Robert A. Pumphrey Funeral Home/Rockville, Inc. M01305 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ aloms disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** hroniche Sequentially list conditions, Examine Due to for as a gunsuausnos of if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events use as the burial-transit and Due to (or as a consequence of): resulting in death) Last been signed by the attending physician should be detached for use as the buria Physician/Medical certificate be Box 68760 IF FEMALE yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year or Attending Physician: The law requires that the death 5 Other (specify) Pregnant at time of death 1 L Yes 2 L 9 L Unknown Division of Vital Records, P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ò 1 Tes 2 X No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed after death.

Director: After this certificate Yes 2 X No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) filled in by the funeral director, Certificate: To Be Other: 4 \(\text{Nursing Home} \) 5 \(\mathbb{X} \) Residence \(6 \text{ \text{Other}} \) Other \(\mathbb{Specify} \) 1 🗆 Yes 2 🗶 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27, Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at 1 X Natural injury work?
1 Yes 2 No 5 Pending Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

To the Hospital 24 hours within 24 hor To the Fune completely fi

31. Date filed (Month, Day, Year) State FEB 0 9 2012 Registrar

(Check

3 🗆

29b. Signature and title of Pertification

911 Russell Avenue, Gaithersburg, Maryland 20879 Stephen H. Dolinsky, M.D. 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D0020148

29d. Date signed (Month, Day, Year)

February 7, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	of Maryland				Mental Hy	giene	010	00560
		-	Registrar 1. Decedent's Name (First, Middle, Last)		Cer	tificate of L)eath	_	Reg. No.	UIZ	03333
	Physicia		Thekla E.	Bri	ınner			2. Date of Dea		2012	3. Time of Death 5:00 A M
	Medic Examin		4a. Facility Name (if not institution, give street and nui		1111101	4b. City. Town, or	r Location of Deatl			ty of Death	J.00 A
	LXdiiiii	٠,	Manor Care Bethesda			Bethe				ntgome	ry
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. las	t birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt		9. Birthp Count	lace (State or Foreign
	Director		212-74-8122 1 ☐ M 2 🖾 F Usual Residence of Decedent	75	Yrs.			October		Gern	
	and show at	or	10a. State 10b. County		Town or Loc	ation		Toctober	4, 1930		Od. Inside City Limits
	Maryla 18a-f	Director	Maryland Montgomery	Pot	omac						1 🗆 Yes 2 😾 No
	a or 2	iQ le	10e. Street and Number		- Carrier L	10f. Zip Code			10g. Citizen o	f What Count	try?
	th with	Funeral	11011 Lamplighter Lane			20854			United		
	r deat		Armed F	edent Ever in U.S. prces? 2 X No	13. W	as Decedent of H Yes, specify Cuba	ispanic Origin? (Sp n, Mexican, Puert	pecify Yes or No- o Rican, etc.)		ace - America ack, White, e	
21215-0036	s afte ral", o Exan	ed by	3 Widowed 4 Divorced If Yes, Gi	ve	1	☐ Yes 2 🗓 No	Specify:		Specif	fy: Whit	۵.
2-0	nour "natu dical	Completed	15. Decedent's Education (Specify only highest grade completed	0		ent's Usual Occup ind of work done o		kina	16b. Kind of		
7	hin 72 ne. than '	om	Elementary/Secondary (0-12) College (life. DC	NOT use retired)	aring most or wor	Kinig			
i D	ed wit Hygie other	Be C	12 17. Father's Name (First, Middle, Last)		_ Homer	naker	19 Mother's Na	me (First, Middle,	Own F		
au	be fill ental rked c	To	Kurt E. Sippel				Elsa Fi		Waldell Gulllal	ne,	
Maryland	hould and M s max		19a. Informant's Name/Relationship (Type, Print)		19b. Mailin	g Address (Street			r, City or Town,	State, Zip C	ode)
Σ	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Merital Hygiene. If health and Merital Hygiene. If marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		John E. Brunner/ Husbar	nd	1101	l Lamplis	ghter Lai	ne, Poto	mac. Ma	rvlan	1 20854
	e 1 ar t of He If iter or oth		20a. Method of Disposition 1 ☐ Burial 2 🏋 Cremation 3 ☐ Removal from	20b. Pla	ce of Dispos	sition (Name of atory or other place TY	ce)	Date	20c. Location	a - City or To	wn, State
Ħ,	t. Page rtment o rtant: If rjury or		4 Donation 5 Other (Specify)	Cr	emātor	ium. Inc	8.	ruary 2012	Bethe	sda. M	laryland /
Ba	permit. Page 1 Department of Important: If it any injury or o		21. Signature of Europeral Service Licensee	≠ M0033	5 ²² .	Name and Addre Rockville Rockville	ss of Facility Koles, Inc. Marvla	BOO West	Pumphre Montgo 0-2805	mery A	eral Home/ Avenue
Н			23a. Part 1. Enter the disease or complications that shock, or heart failure. List only one cause on e	caused the death. ach line.							Approximate Interval Between
4	hysician		Immediate Cause (Final disease or condition Met	astatic	Ovaria	an Cancer	c				Onset and Death
	Medical Examiner			(or as a conseque							
1		Jer		re1 Obstr		1				_	
	ited d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury	betes Ty	pe II						
	executed an and irial-transi	I Ex	that initiated events resulting in death) Last C. Due to	(or as a conseque	nce of):						
09	requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	dical	d. Neu	ropathy							
687	ertifica ding p		IF FEMALE: 23c. If yes ou	tcome of pregnand	°V						
Вох	death c	by Physician/Me	in the past 12 months?	Birth 2 Fetal o	death 3 🗌	Ectopic pregnand Other (specify)	СУ			Date of delive Month	ry Day Year
B	the de	hysi	9 Unknown 9 Unk								
O.	law requires that the tas been signed by tl e 2 should be detach	ьу Р	Part II. Other significant conditions contributing to a	death but not resul	ting in the ur	nderlying cause giv	ven in Part I.	23e. Did to	obacco use cor	ntribute to the	e cause of death?
ds,	en sig	ted						1 🗆	Yes 2 ☐ No	3 🗌 Prob	ably 4 🔀 Unknown
OS C	las 1as	Completed						24a. Was autor	osv	prior to cor	sy findings available npletion of cause of
Ž.	sician: The law i certificate has b lirector, page 2 s		25					1 🗆 Yes	2 No	death?	2 🗌 No
ıta	ysician: is certific director,	m	25. Was case referred to medical examiner? 1 Yes 2 X No Hospital: 1			Toth	ace of Death (Che er: 🚜				
 	g Phy er this neral c	e: To	27. Manner of Death 28a. Date		8b. Time of	28c. Injur	y at	lome 5 Resid			
on	endin eath. or: Aft	ficat	2 Accident Investigation	nth, Day, Year)	injury	M 1 🗆	Yes 2 No				
Division of Vital Records,	Hospital or Attending Physician: The Za hours after death. Funeral Director: After this certificate Petely filled in by the funeral director, page	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place build	e of Injury - At hom ing, etc. (Specify)	e, farm, stre	et, factory, office		28f. Location (S City or Tow		ber or Rural	Route Number,
٥	pital o		29a. Certifier 1 X Certifying Physician: Tothe	nest of our linewiller	des doeth s	an unual at the time.	a data and alace	and due to the or	augusta) and ma	nnor on otato	d
	To the Hos within 24 hor To the Funcompletely	Medical	(Check 2 Medical Examiner: On the ba	sis of examination a	and/or investi	gation, in my opinio	on, death occurred	at the time, date a	ind place, and d	lue to the cau	se(s) and manner stated.
	To the within 2 To the I complete	4	29b. Signature and title of certifier	out on	Nd	29c. Licenso			29d. Date sign		
			1 .1 /	ZVY			D53691		Februa	ary 6.	2012
			30. Name and address of person who completed cau						TO COMPANY		
سر	Stat		Ajay Reddy, M.D. 3200/ 31. Date filed (FEB'0 '9') 2012	Registrar's Signetur	ro .		Rockvill	e, Mary	land 20	852	
	Registra	ar	31. Date filed (FEB 0 197) 2012	ya B.	park						

DHMH 17 Rev 06-2011

12-01016

John Murray Bradley, Jr.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

		For State				Cer	tificate o	f Dea	th			R	eg. No.			
Physician		. Decedent's Nam	e (First, Midd	le,Last)							2	Date of Dea Month	ith Day	Year		3. Time of Death
Andical Examine	er		John	M.	Bradl	ey, Jr	•					February	3, 201	2		1247 hrs
	4	a. Facility Name (i 3806 Blenhe		on, give stre	et and numb	er)			, Town, or L enix	ocation of	Death			County of		nty
Funeral	5	. Social Security N	lumber	6. Sex	7.	Age (In yrs. la	ast birthday)	If Ur	nder 1 Year	If Under	_	8. Date of Bi	rth(MM/E	DD/YYYY)		place (State or
Director		215-68-00	078	1 <u>X</u> M	2F	57	Yr	Mon	ths Days	Hours	Min.	Dec. 1	16,	1954	Foreign Cou	ntry)Maryland
b	_	Isual Residence of 0a. State	f Decedent 10b. County			10c City	Town or Loca	tion				-				10d. Inside City Limits
w any	- ['	MD.	Balti	more		1										1 Yes 2 X No
Maryland 28a-f show	֡֡֞֞֞֞֞֡֡֞֞֞֞֞֡֡֡֡֞֞֞֜֞֡֡֓֓֡֡֡֡֡֡֡			MOLE		Pn	oenix	10f 7	ip Code				Og Citiz	en of Wha	at Count	rv?
JD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f sho marked other than "natural", or items 23a or 28a-f sho marked other than "natural", or items 12a or 28a-f sho marked event, the Medical Examiner must be notified at one.	Torior 1	0e. Street and Nu		m Road	d			101. 2	21131				og. om		5A	.,.
with t		1. Marital Status			Was Deced	ent Ever in U.	.S. 13. W	as Dece	dent of Hisp cify Cuban,	anic Origi Mexican	n? (Spe	cify Yes or No	o-	14. Race · White		an Indian, Black,
		Never Marri Widowed		larried 1 vorced If Ye	Yes	2 No	"		2 X No			, , , , , , , ,		Specify: \	Whit	e
rs afte	라	15. Decedent's Ed	-	or D	ates:	completed)	16a. Decede	nt's Usu	al Occupation	on (Give ki				and of Bus		
2 hour		Elementary/Seco			College (1-4		during r	nost of w	vorking life.	DO NOT u	use retire	d)				
0036 within 72 jene.	Completed				+4		Busin	ess	Owner					ie & 3	_	rits
5-00 led wit Hygien other	5 1	7. Father's Name	(First, Middle	, Last)				_	1	8.Mother's	Name (First, Middle,	Maiden	Surname)		
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	e n	John 1								Alio	ce (adle			
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours afte Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", injury or other tranmante event, the Medical Examiner	의	9a. Informant's Na				n Lou			ss (Street chuste			ıral Route Nu arrett				
, MD and 2 sho salth and cm 27 is		Martha Oa. Method of Dis		y/ 31	Ster 1		Place of Dispo					Date				Town, State
ore ges 1 a t of H t of H		1 X Burial 2			Removal from	State	crematory or o		-		2 - 8-	12	Į į	lydes	MΓ).
Baltimore, permit. Pages 1 ar Department of Hei Important: If ite injury or other tr		Donation 5			/					0		uneral				
Dem Perm	24	/(100	1-1	_				1050	York	Rd.	Towsc	n, M	1D. Z	1204	
Physician	1	23a. Part I. Letter the	ne dia ase, o	complicati	ons that caus	sed the death	. Do not enter	the mod	le of dying, s	such as ca	ardiac or	respiratory ar	rest, sho	ck, or hea	irt	Approximate Interval Between Onset and
/Medical. £xaminer		mmediate Cause					ic Card	iova	ascula	r Ds	ie <u>as</u>	<u>e</u>				Death
		or condition resulti	ng in death)	Due	to (or as a co	onsequence o	of):									ì
		Sequentially list co f any, leading to in	mmediate		to (or as a co	onsequence o	of):									
	ε۱۰	cause. Enter Unde (Disease or injury bevents resulting in	that initiated	C.	to (or as a co	onsequence o	of):									
cecuted				d				-		. 10					_	
ia ia	Medical	▼ UNPENDED)	AM	MENDED 2	3a,27,	per me	, g92	4 2-13	3-12	sm					
760, cate be ex physician the burial	8	F FEMALE: 3b. Was decedent	pregnant in			tcome of preg	nancy		th 3	Tetasia			230	d. Date of Month		ay Year
Box 68760, death certificate be the attending physic dor use as the bur	Physician	past 12 month		1	Live birt	n nt at time of de	o oth	-etal dea Other (S		Ectobic	pregnan	icy .		WOTTER		uy rou
Box death death d for u	Š	1 Yes 2	No 9 Ur	nknown 9	Unknow	n		J. 101 (-								
that the d		Part II. Other sign	ificant cond	itions con	tributing to d	leath but not r	resulting in the	underly	ing cause gi	iven in Pai	rt I.					he cause of death?
rics that to signed by I be detac	Completed by											10000		3202107		ably 4 🗹 Unknown
ords, w requir s been s should	<u>ğ</u>											24a. Was	psy	р	rior to c	opsy findings available ompletion of cause of
Reco	Ĕ												ormed? 2 √ N		leath?	s 2 No
tal Recision: The certificate ector, page	ည် - ကို	25. Was case refe	rred to medic	_						of Death (<u> </u>					
Vital I		examiner?	2 No	Hosp	ital: 1 Inp	patient 2	ER/Outpatie		J 00/1			Home 5				Scene
ion of tending Ph. eath.		27. Manner of Dea		1	28a. Date of (Month, D	Injury (ay,Year)	28b. Time o	f Injury	I	yatWork′ ′es 2		28d. Describe	e how inji	ury occurr	ed	
ttend death. etor:	ä	2 Accident		nding estigation			<u> </u>					Ope Ition	(Cten ot a	and Numbe	or or Du	ral Route Number, City
Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certifi within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Certification:	3 Suicide		uld not be ermined	(Specify)	of Injury - At F	nome, farm, str	eet, ract	ory, onice bi	unaing, et	c.	or Town,		and Numbe	ei oi itu	a Notice Number, Ony
Lospits 4 hours unnerally fill	ဋီ-	4 Homicide 29a. Certifier	Certifying	Physician:	To the hest	of my knowled	dge, death occ	urred at	the time, da	ite and pla	ice, and	due to the car	use(s) ar	nd manner	as state	ed.
To the Howithin 24 h		(Check only 1 one) 2 🗹	Medical Ex	aminer: On	the basis of	examination a	and/or investig	ation, in	my opinion,	, death oc	curred at	the time, dat	e and pla	ace, and d	lue to the	e cause(s)
F 3 F 8	₽	29b. Signature an		ier		-			29c. License				1	-	٠.	nth, Day, Year)
		m	ius						O.C.	И .Е.			Feb	oruary 4	, 2012 ———	
		30. Name and add		on who com	pleted cause	of death (Iter	m 23a) W. Baltim	ore St	reet Balt	imore M	MD 21:	223				
Sta	ite	Ling Li, MD					ure fac									
Registr	ar	31. Date filed?	D 11.0 5	UIZ	BAN	w p	· par	Kal			_					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of Maryland	I / Department of I Certificate of I			2012	03565
	Diversials	/	Registrar 1. Decedent's Name (First, Middle, Last)	`	Poll	Death	Reg. 2. Date of Death		3. Time of Death
Mr.	Physicia Medic	al ্	4a. Facility Name (if not institution, give str	reet and number)	4b City Town o	r Location of Death	FEBRUALY	7, 2012 4c. County of Death	. 0441 M
	Examin		The Johns Hop	Kins Hospit	al Baltin	nore Cr	ty	NA	
80	Funeral Director			7. Age (In yrs. las	t birthday) If Under 1 Year Months Days Yrs.	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Yea 10/23/4	ar) Coul	place (State or Foreign htry)
	and show	Į.	Usual Residence of Decedent 10a. State 10b. County		Town or Location		1010011		10d. Inside City Limits
	he Maryland or 28a-f show o notified at	Director	MD N/A 10e. Street and Number	Be	1 Himune		10g	Citizen of What Cou	1 Ves 2 No
	n with the	Funeral	633 N. Aisq	with St.	212	212		USA	,
920	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Memtal Hygiene. T is marked order than "natural", or items 23a or 28a-f sho item 27 is marked order than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at	þ	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1 Yes, Give Year or Dates.	13. Was Decedent of I If Yes, specify Cub	an, Mexican, Puerto F	cify Yes or No- Rican, etc.)	14. Race - Ameri Black, White, A Fru Specify: A m	etc.
215-0036	72 hour n "natu fedical	Completed	15. Decedent's Edu (Specify only highest grade	completed)	16a. Decedent's Usual Occu (Give kind of work done life, DO NOT use retired	during most of working	16k	o. Kind of Business/li	ndustry
	d within ygiene. her tha nt, the N	Be Cor	Elementary/Secondary (0-12)	College (1-4 or 5+)	Homema	ken		Self	
land	should be filed within and Mental Hygiene, is marked other tha aumatic event, the f	To B	17. Father's Name (First, Middle, Last) Stevenson Bel	1			(First, Middle, Maid e Bell	fen Surname)	
Maryland	2 should th and N 7 is ma trauma		19a. Informant's Name/Relationship (Type Donothy B. Egg)	Print) Potas/Daushter	19b. Mailing Address (Street				Code)
	a U +		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ R	20b. Pla	ace of Disposition (Name of	, ,	ate 200	c. Location - City or 1	
Baltimore,	t. Pag tment rtant: ijury o		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral / ervice ✓ ensee	[<u>M</u> †	Zion Cem. 22. Name and Addre	ess of Facility / to	112 10	se F. SVS	MD P.A.
B	Depar Impo any ir		1	(5126 B	elain Roc	ad, Balt	more, ME	21206-5105
	bysician/		23a. Part 1. Enter the disease, or complice shock, or heart failure. List only one Immediate Cause (Final	cations that caused the death. cause on each line.	4	ng, such as cardiac o	r respiratory arrest,		Approximate Interval Between Onset and Death
	Medical Examiner		disease or condition resulting in death)	Due to (or as a conseque					
		iner	Sequentially list conditions, if any, leading to immediate	Due to (or as a conseque	ence of):				
	be executed sician and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseque	ence of):				
09,	ate be ex ohysician the buria	dical	C _d						
Box 68760	hat the death certificat ed by the attending ph detached for use as th	Physician/Medical	in the past 12 months?	3c. If yes, outcome of pregnan 1 ☐ Live Birth 2 ☐ Fetal 4 ☐ Pregnant at time of de	death 3 Ectopic pregnar	псу		23d. Date of deli Month	very Day Year
P.O. Bo	t the dea by the a stached	Physic	1 Yes 2 No g Unknown	9 Unknown		ince in Deat I	00 0000		the second of death 2
ds, P.	requires that been signed should be de	þ	Part II. Other significant conditions con	tributing to death but not resu	iting in the underlying cause g	jiven in Part I.		co use contribute to	obably 4 Unknown
Records,	The law ate has page 2	Completed					24a. Was an autopsy performed	prior to o death?	opsy findings available ompletion of cause of
of Vital	Physician; The this certificate ral director, pag	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	ospital:		Place of Death (Check her: 4 \sum Nursing Ho		e 6 Other (Speci	fy)
n of	ding Ph th. After th funeral		27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day, Year)	28b. Time of injury 28c. Inju		28d. Describe how i	njury occurred	
Division	il or Attendi s after death. I Director: A d in by the fi	Certificate:	3 Suicide 6 Could not be 4 Homicide	28e. Place of Injury - At hor building, etc. (Specify)	ne, farm, street, factory, office		28f. Location (Stree City or Town, S	t and Number or Rur tate)	al Route Number,
	To the Hospital or A within 24 hours after To the Funeral Direct completely filled in b	Medical	(Check 2 Medical Examine	cian: To the best of my knowled cr: On the basis of examination Practitioner: To the best of m	and/or investigation, in my opin	nion, death occurred at	the time, date and p	lace, and due to the o	ause(s) and manner stated.
	To th Withir Comp		29b. Signature and title of certifier		29c. Licen	no number	204	Data signed (Month	Day Year)
			30. Name and address of person who co		23a) (Type, Print)	600 N.	Walfe St.	Baltimere	7, 2012 MD, 21287
	Sta Registr		31. Date filed (Month, Day, Year) FEB 0 8 2012		parle				

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ Srown -e. brug ra Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Examiner Bultimore Saint Joseph Medical Center 9. Birthplace (State or Foreign 8. Date of Birth If Under 24 Hrs. **Funeral** (Month, Day, Year) Country) Director 1 🗆 M 2 📝 F 78Yrs. irginia March Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location must be notified at Director 1 Ves 2 No altimore 10g. Citizen of What Country? 10e. Street and Number 21209 USA Funeral or items 23a lamaria Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, 11. Marital Status the Medical Examiner Black, White, etc. þ 1 Never Married 2 Married Yes 2 No Maryland 21215-0036 1 Yes 2 No Specify Blac If Yes, Give "natural", 3 Widowed 4 Divorced Completed Year or Dates (Give kind of work done during most of working the DO NOT use retired) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) should be filed within 72 I n and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4 or 5+) eamstress Be 18. Mother's Name (First, Middle 7 Father's Name (First, Middle, Last) 2 Department of Health and Menter Important: If item 27 is marken, any injury over 1 sinclair Blivia 21209 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) dward Balto MD 4803 iamarind 3altimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 Surial 2 Cremation 3 Removal from State Dwings Mills 13/2012 jarri Son Forest 4 Donation 5 Other (Specify, 21. Sign Huy of Funeral Servi Howell HARRIE 22. Name and Address of Facility Funera MD Liberty 4600 Heights 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ a Ischemic disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of, burial-transit Due to (or as a consequence of): attending physician Physician/Medical the use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d, Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year for Hospital or Attending Physician: The law requires that the death Pregnant at time of death 5 Other (specify) signed by the at d be detached for Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Gastrointestinal 24b. Were autopsy findings available End Stage Renal Disease 24a. Was an prior to completion of cause of death? page 2 perform 1 Yes 2 No 1 Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral directors. 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending injury Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar only one

29b. Signature and title of certifie

7601 Osler Drive

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

HIP Pa Registrar's Signa 8 FEB 0

D5274

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - State Registrar	Cert	ificate of L	Death		Reg. No.	112	03301
	Dhysisis		1. Decedent's Name (First, Middle, Last)				2. Date of De Month		Voor	3. Time of Death
	Physicia Medio		Marian C. Cavey				Februa	ry 7, 20)12)12	9:30 P ^M
	Examin	er	4a. Facility Name (if not institution, give street and number)		4b. City, Town, or	Location of De	ath	4c. County	of Death	
and the			St. Elizabeth Nursing Home		Balti				N/A	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. la.	st birthday)	If Under 1 Year Months Days	If Under 24 H Hours Mi		th y, Year)	g. Birthp Count	lace (State or Foreign
	Director		216-48-8720 Usual Residence of Decedent	9 Yrs.			Dec 16		Mars	vland
2	how	7	Codd Nesidened of Decedent	Town or Loca	ation	1	1000 10	9 1722		0d. Inside City Limits
alvia	a-f s ffied	Director	Maryland Anne Arundel	Clan	Diversi o					1 Yes 2 No
A	or 28 e not		10e. Street and Number	Gren	Burnie			10g. Citizen of	What Coun	
vith t	23a ist be	Funeral	808 Barkwood Road		210	161			JSA	-,,
ath	ems	ůņ	11. Marital Status 12. Was Decedent Ever in U.S		as Decedent of H	ispanic Origin?	Specify Yes or No-		ce - America	an Indian,
6	or if	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 💢 No		Yes, specify Cuba		erto Rican, etc.)		ck, White, e	
03	ural"		Widowed 4 ☐ Divorced If Yes, Give Year or Dates.	1	☐ Yes 2 🏋 No	Specify:		Specify	Whit	te
21215-0036 within 72 hours affer	"nat	Completed	15. Decedent's Education (Specify only highest grade completed)		ent's Usual Occup nd of work done o		rorkina	16b. Kind of B	usiness/Ind	dustry
121	ne. than	E	Elementary/Secondary (0-12) College (1-4 or 5+)	life. DO	NOT use retired)	3				
(A) 18	Hygie ther nt, th	Be C	17. Father's Name (First, Middle, Last)	Home	maker				n Hon	ne
anc	ntal li	일					lame (First, Middle, a C. Rob		3)	
7	d Me mark mativ		Walter D. Gordon 19a. Informant's Name/Relationship (Type, Print)	401- 14-75-	A -1 -1 (O4 4				24-4- 7/- 6	1(-)
Maryland Should be filed	th an 27 is trau			1			Rural Route Numbe en Burnie			ode)
6	Heal tem other		Gilbert N. Cavey Sr., Son	ace of Dispos	ition (Name of		Date	20c. Location		wn. State
Baltimore,	Department of Health and Mental Hygiene. Important If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		1 Parial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	metery, crema adow : 1	atory or other place doe Park	(e)	10/12		-	
	ortar injur		21. Sunature of Funeral Service Licensee Zhomas Grego	orial	Park Name and Addres	s of Facility		Elkridg		
ä	Depar Impor any ir		Thomas Ture	1 3	acNabb F 01 Frede	uneral rick Ro	Home, P.A	A. sville	Marul	and 21228
	9		23a. Part 1. Enter the disease, or complications that caused the death	. Do not enter	the mode of dyin	g, such as cardi	ac or respiratory ar	rest,	TRILLY I	Approximate
Pin	ysician/		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	K. G	ardwa	sular	Dros are		3	Interval Between Onset and Death
	Medical		disease or condition resulting in death) a. Due to (or as a consequence)			a v - Cops			-	yeur
	xaminer		Occupation list and little							
	=	Examiner	Sequentially list conditions, b. Due to (1282 51986) a cause. Enter Underlying	эпск об:						
A B	nd transi	xam	Cause (Disease or injury that initiated events c							
e exe	vian a		resulting in death) Last Due to (or as a consequence)	ence of):						
68760 ertificate b	physician and s the burial-transit	/Medical	d						_	
687 ertific	ding p		IF FEMALE: 23c. If yes, outcome of pregnant	ICV.						
Box death c	atten for u	ciar	in the past 12 months?	death 3 🗌	Ectopic pregnand Other (specify)	су			ate of delive onth	Day Year
<u>യ</u> ഉ	/the	Physician	1 Yes 2 4 Pregnant at time of dig 9 Unknown 9 Unknown	Jun 0						
Pat #	been signed by the attending p should be detached for use as	by Pł	Part II. Other significant conditions contributing to death but not resu	Ilting in the un	derlying cause giv	en in Part I.	23e. Did to	obacco use cont	ribute to th	e cause of death?
illes	sign ld be	d b					_ 1 🗆	Yes 2 No	3 🗆 Prob	pably 4 Unknown
Orc v req	shou	Completed					24a. Was			sy findings available
ec he lav	age 2	omi						rmed?	prior to con death? 1 Yes	npletion of cause of
Division of Vital Records, P.O. tall or Attending Physician: The law requires that the	certificate has t	Be C	25. Was case referred to medical		26. PI	ace of Death (Ci	1 L Yes	2 No	i Li tes	2 🗆 140
Vit.	this cert	To E	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 I	R/Outpatient	3 DOA Othe	er: 4 Nursing	Home 5 Resid	dence 6 🗀 Oth	er (Specify)	
of Plant	fter th		27. Mannor of Death 28a. Date of injury 1 Natural 5 □ Pending (Month, Day, Year)	28b. Time of injury	28c. Injury work	y at	28d. Describe h	now injury occurr	ed	
iendii	or: All	lica	2 Accident Investigation 3 Suicide 6 Could not be			Yes 2 □ No				
ViS or Att	fter d irect in by	Certificate:	4 Homicide determined 28e. Place of Injury - At hor building, etc. (Specify)	ne, farm, stree	et, factory, office		28f. Location (S City or Tow	Street and Numb in, State)	er or Rural	Route Number,
	ours a						1			
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate be executed	within 24 hours after death. To the Funeral Director: After the completely filled in by the funeral.	Medical	29a. Certifier (Check 2 Medical Examiner: On the best of my knowle	and/or investig	gation, in my opinio	on, death occurre	ed at the time, date a	ind place, and du	e to the cau	ise(s) and manner stated.
o the	ithin o the	Σ	only one) 3 Certifying Nurse Practitioner; To the best of m 29b. Signature and title of certifier	y knowleage, o	29c. License		d place, and due to t	ne cause(s) and r 29d. Date signe		
	> - 0		Rarlar Rypland no		D24	1781		2 9	201	2
	5		30. Name and address of pe son who completed cause of death (item	23a) (Type: Pri	int)	, , ,		0	- 0 1	
	1)		Mailes K GILLAMIN M.D.	1001	Pine Ho	elakts	₩L \$300	balto.	mo:	21229
	Stat		31. Date filed (Month, Day, Year) 32. Registrar's Signatu	ıre	1.0	J				
	Registra	ar	FEB 0 9 2012 Se	back	<u> </u>					
DHMH	17 Rev 06-2	2011	1000							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Physician/ Month ISA M EONARD 01 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** DANDTOWN DAUTIMORE 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs 7. Age (In yrs. last birthday) Funeral Days Min. 1 ₩ M 2 □ F Months Hours Director 214-16-5021 Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10c. City, Town or Location Director 1 Yes 2 No BAUTIMORE MID 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral U. S. 21227 1000 N. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. Armed For Black, White, etc. 1 Never Married 2 Married Yes 2 No Completed by 1 Yes 2 No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) UNKNOWN UNKNOWN Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) UNKNOWN UNKNOWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ST. BANTIMERE, MD JONES - SOUND WORKER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State KEIDTERSTOWN MD 4 ☐ Donation 5 ☐ Other (Specify) 1-24-12 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 2827 HUSSON ST. SKARDA FINERAL 134-23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Interval Between a HYPERTENSIVE CARDID VASCULAR Immediate Cause (Final DISEASS Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit Cause (Disease or iinjury that initiated events and Due to (or as a consequence of): resulting in death) Last the attending physician ned for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by PULMONARY CHRUNIC UBSTRUCTIVE 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an ALZHENNERS performed? Yes 2 N 1 Yes 2 No this certificate 25. Was case referred to medical examiner?

1 Yes 2 No 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 - Residence 6 - Other (Specify) ျ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: after death. Director: After work? Natural 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined within 24 hours a Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 02-08-2012 D0059107 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MO REISTERSTOWN CENTER DRIVE UMA 210 BUNNESS 31. Date filed (Month, Day, Year) State FEB 0 9 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician/ 37 AM Claudia Wesley Cox 2012 Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death -Examiner Roseda Franklin Square Haspita 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday, **Funeral** Months Hours 08/25/1943 **Director** 220 38 8309 1 🗆 M 2 💢 F 68 Yrs. Maryland Usual Residence of Deceden 28a-f show 10a. State 10b. County 10d. Inside City Limits with the Maryland 10c. City. Town or Location notified at Director 1 Yes 2 No Maryland Baltimore Essex 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? ò "natural", or items 23a or Funeral United States 21221 1104 Oak Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Bace - American Indian 11. Marital Status Armed Force Black, White, etc þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 e X No white 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Completed 3 Widowed 4 Divorced and Mental Hygiene.
is marked other than "natural aumatic event, the Medical Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Financial Analysist Aero-Space lox, Claudia Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ည Wesley McCormick Mary McCauley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1104 Oak Avenue Essex Maryland 21221 Department of Health ar Important: If item 27 is any injury or other traconce. Thomas J. Cox (son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Donation 5 Other (Specify) 2/8/2012 Baltimore, Maryland Oak Lawn Cemetery Funeral Service Licensee 22. Name and Address of Facility Bruzdzinski Funeral Home PA Old Eastern Avenue Essex Maryland 21221 Enter the disease, or complications that carset the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each time. Approximate Interval Between Onset and Death Immediate Cause (Final Physician 100 disease or condition Medical resulting in death) Dusto (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner nding physician and use as the burial-transi Cause (Disease or injury that initiated events resulting in death) Last the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown been signed by the a should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Vunknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 2 🗹 No ျှ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No Manner of Death 28b. Time of I Director: After the Certificate: 28d. Describe how injury occurred injury 5 Pending Natural Accident Investigation 6 🗌 Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a

To the Funeral C

completely filled hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 only one) 29b. Signature and title of o 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 Baltimore MD

DHMH 17 Rev 06-2011

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2 or 2 12:14 PM Bernard Clifford, Nelson Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death Examiner 4c. County of Death NA Baltimore Union Memorial Hospital Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** (Month, Day, Year) 06-11-49 Hours Min 218-46-8939 62 Director 1 🖾 M 2 🗆 F MD Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10b County 10c. City, Town or Location 10d. Inside City Limits Director Baltimore 1 X Yes 2 No MD NA 10e. Street and Number 10g. Citizen of What Country? Funeral 21217 USA 832 Brooks Lane Apt.#2 items death "natural", or item edical Examiner n 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc African 1 Never Married 2 Married Completed by ☐ Yes 2 XNo 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give 3 Widowed 4 Divorced Specify: American Year or Dates ed other than "nature event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Flementary/Secondary (0-12) 10th Grade and Mental Hygiene. Laborer Construction Co. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Clifford Young Idella Philip Lee 19a. Informant's Name/Relationship (Type, Print) Sister 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. Forestine Clifford 832 Brooks Lane Apt #2 Baltimore,MD 21217 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State 02-06-12 Catonsville, MD Metro Crematory 4 Donation 5 Other (Specify) 22. Name and Address of Facility Wylie Funeral Home P.A. 21. Signature of Funeral Service Licensee 638 N. Gilmor Street Baltimore, MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Septic Shock due to infected Tem-POP Graft Onset and Death Immediate Cause (Final -Physician 3 hrs disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions Examiner rany, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of and -tran that initiated events Due to (or as a consequence of) resulting in death) Last **burial** physician s the burial Physician/Medical death certificate be Box 68760 as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Dav Pregnant at time of death 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Unknown Hospital or Attending Physician; The law requires that the Records, P.O. signed by Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has page 1 Yes 2 No Yes 2 N Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 No Other: 1 Yes pital: 1 Inpatient 2 Inpatient 3 Inpatient 2 Inpatient 2 Inpatient 3 Inpatient 2 Inpatient 3 Inpatient 3 Inpatient 2 Inpatient 3 Inpatient 잍 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death Certificate: 28c. Injury at work? 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After of completely filled in by the funer (Month, Day, Year) 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 1669763488 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) University PKWY, Baltimore, MD 21218 201 East Pelman Kharazi WD 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State of Ma	ryland /		artment of H <i>rtificate of D</i>			giene Reg. No	7012	03571	
ı	Physicia	ın/	1. Decedent's Name (First, Middle, Last)	Mand				2. Date of De	ath		3. Time of Death	
	Medic Examin	al	Gertrude 4a. Facility Name (if not institution, give street and number)	Mari	a l	Davis 4b. City, Town, or	Location of Dea	Februa		3, 2012 County of Death	3:15 AM	
19.15°			Summit Park Nursing Home 5. Social Security Number 6. Sex 7. Age (In yrs. last 214-84-0375 1 \(\triangle M \) 2 \(\triangle F \) 6.			Months Days Hours Min.					Baltimore 9. Birthplace (State or Foreign Country)	
A	Funeral Director											
			Usual Residence of Decedent	86	Yrs.			May 11	., 19	925 Ge	rmany	
	ıryland a-f sho ied at	Director	10a. State 10b. County MD Howard	10c. City, Tov	wn or Lo	Columbia					10d. Inside City Limits 1 ☐ Yes 2 👿 No	
	the Ma or 28% e notif	Dire	10e. Street and Number			10f. Zip Code		1	10g. Cit	izen of What Co		
	n with	Funeral	7070 Cradlerock Way, #102	2		2	1045			USA		
'	or item	by Fu	11. Marital Status 1 Never Married 2 Married 12. Was Decedent Evarmed Forces? 1 Never Married 2 Married 1 Yes 2 X		13.	Was Decedent of His If Yes, specify Cuban	spanic Origin? (, Mexican, Pue	Specify Yes or No- erto Rican, etc.)		14. Race - Amer Black, White		
Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ted b	3 X Widowed 4 □ Divorced If Yes, Give Year or Dates.	10		1 Yes 2 X No	Specify:			Specify: Wh:	ite	
15-(72 hou n "nat fedica	Completed	15. Decedent's Education (Specify only highest grade completed)		(Give	dent's Usual Occupa kind of work done du OO NOT use retired)		orking	16b. K	ind of Business/l	Industry	
212	within giene. er thai		Elementary/Secondary (0-12) College (1-4 or 5-	+)		nny			C	hild Ca	ce	
pu	e filed tal Hy ed oth event	To Be	17. Father's Name (First, Middle, Last)		18. Mother's Nar				ne (First, Middle, Maiden Surname)			
12	d Men marke matic		Joseph 19a. Informant's Name/Relationship (Type, Print)			ng Address (Street a		arolyne	r City or		aas Codol	
Ma	d 2 sh alth ar n 27 is er trau		Peter J. Davis, son			Hughes A		Sparrow				
Baltimore,	e fan tof He If item or othe		20a. Method of Disposition 1 □ Burial 2 ※ Cremation 3 □ Removal from State	20b. Place cemet	of Dispo	osition (Name of matory or other place	·)	Date	20c. Lo	ocation - City or	Town, State	
<u>H</u>	it. Pag intment intant: njury o		4 Donation 5 Other (Specify)			ematory,				1timore		
Ba	Departiment Department Important Important Information		21. Signature of Funeral Service Licensee George I	MacNabl) 2	2. Name and Address 299 Fred				nety of more, MI		
P			23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line.	the death. Do	not ent	er the mode of dying	, such as cardia	ac or respiratory ar	rest,		Approximate Interval Between	
, Nov.	Phynician/ Medical		Immediate Cause (Final disease or condition resulting in death)	te R	ev	al Fa	Jun				Onset and Death	
	Examiner		Cocch		e ot): 2 S 1 A	a 6)	ande				desc	
	n ti	niner	Sequentially list conditions, if any, leading to him conditions cause. Enter Underlying				,					
D	ecuter and al-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a	consequence	e of):		,					
õ	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical	d									
3876	ertificat ling ph	/Mec	IF FEMALE:	of programov					\neg			
P.O. Box 68760	ath ce attend	by Physician/M	1 Veg 2 No. 4 Pregnant at	Ectopic pregnancy Other (specify)				23d. Date of delivery Month Day Year				
о В	the deby the tached	hysi	9 Unknown 9 Unknown									
P.	requires that the death certific been signed by the attending p should be detached for use as	by F	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unkno									
ords	been should	letec						24a. Was			copsy findings available	
3ec	The law te has bage 2	Completed						auto perfo	psy ormed?	prior to death?	completion of cause of	
tal	Physician: The law r r this certificate has b eral director, page 2 s	Be	25. Was case referred to medical examiner?									
Ę Ś	Physi this c eral dir	Medical Certificate: To	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatie 27. Manner of Death 28a. Date of injur		Outpatie . Time o	nt 3 DOA Other	4 Nursing	Home 5 Resident			ify)	
o uc	nding ath. r: Aftel ne fune		1 ☑ Natural 5 ☐ Pending (Month, Day, 2 ☐ Accident ☐ Investigation		injury	work?		Zod. Bosonibe i	iow injury	y doddinod		
Division of Vital Records,	I or Attendi after death Director: A I in by the f		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injurbuilding, etc.						f. Location (Street and Number or Rural Route Number, City or Town, State)			
۵	spital of the sp		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
	To the Hospital or Attending Phywithin 24 hours after death. To the Funeral Director, After this completely filled in by the funeral		(Check 2 Medical Examiner: On the basis of exonly one) 3 Certifying Nurse Practitioner: To the	amination and	or inves	stigation, in my opinior	n, death occurre	ed at the time, date a	and place	, and due to the o	cause(s) and manner stated.	
	To t To t		29b. Signature and title of certifier	3		29c. License	number			te signed (Month		
	2		30. Name and address of person who completed cause of de	ath (Item 23a)) (Type.	Print)	-171		rc	0000	+,09,6012	
	3		Dænak Boskuran	3455		silkers.	Am	U 12	Bal	Hime of	W 21223	
	Sta Registra		31. Date filed (Month, Day, Year) 32. Registrar's Signature FEB 0 9 2012									
				7								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1065 D Loving Road Severn Anne Arundel Co. . Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Age (In yrs. last birthday) **Funeral** Days Hours Min Months 227-96-7394 **Director** 1 M 2 W 51 03/21/1960 Virginia 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Maryland Director be notified 1 Yes 2 X No MD Anne Arundel Co. Severn o 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a within 72 hours after death with **Examiner** must 1065 D Loving Road 21144 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. "natural", or by 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 Widowed 4 Divorced Year or Dates Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) traumatic event, the Building Inspector Contracting Company yrs. and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Albert Lee Pickeral Thelma Kniceley Page 1 and 2 should ment of Health and Me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 Mr. William A. Danel, Sr./Husband 1065 D Loving Road Severn, MD 21144 Department of Healt Important: If item 2 any injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 02/09/2012 Glen Burnie, MD Signature of Funeral Service 22. Name and Address of Facility Singleton Funeral & Cremation M01121 | Services PA; 2nd Ave SW: Glen Burnie. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between O et d ath shock, or heart failure. List only one c Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Equantially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of) physiciar Physician/Medical Records, P.O. Box 68760 the as IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Day Unknown g Unknown signed by i Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 2 should Were autopsy findings available prior to completion of cause of 24a. Was an autopsy page death? 2 No Yes 1 Yes Division of Vital 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? 2 1 No Hospital Other: 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence this 27. Manner Death 28a. Date of injury Time of Certificate: 28b. 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending injury s after death. 1 Yes 2 No M 2 Accident Investigation the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide determined building, etc. (Specify) City or Town, State) 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Tpletely (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one) 29b. Signature and title of certifier License number 29d. Date signed (Month, Day, Year) 2012 (1 03 23a) (Type, Print) ause of death (Item ANNAPOLIS.M.D.21401

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2012 Physician/ Month Charles Dyson Feb. 06, 9:01 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Mandrin House Harwood Anne Arundel Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Months Days Hours **Director** 577-76-1344 1 🛣 M 2 🗆 F 56 Oct. 14,1955 Washington, DC Yrs fshow 10a. State 10c. City, Town or Location 10d. Inside City Limits notified at Director · 28a-f MD Prince George's Hyattsville 1 X Yes 2 No 10e. Street and Number 0 10f. Zip Code 10g. Citizen of What Country? ed other than "natural", or items 23a o event, the Medical Examiner must be Funeral 20783 2228 Chapman Road USA should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 X Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: SpecifyAfrican American Completed 3 Widowed 4 Divorced Year or Dates 1976 – 78 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Chef US Government marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Roy T. Dyson, Sr. Frances Smooth other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) .. Page 1 and 2 sh tment of Health a tant: If item 27 i 300 N. Canal St Apt 711 Chicago, IL 60606 Roy T. Dyson, Jr. / brother permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2 🕱 Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Final Journey Crematory 2/09/2012 Woodbine, MD 21. Signature Funeral Service Licenses Going Home Cremation Service P.O. Box 784 MD 21029 Beverly L. Heckrotte, P.A. Clarksville, Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) dean Medical Due to (or as a consequence of) Examiner Sequentially list conditions. bus to (or es a nonsequence of if any, leading to immedicause. Enter Underlying Exami Cause (Disease or injury burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical death certificate be Box 68760 the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ģ in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death 1 ☐ Yes ∠ ☐ g ☐ Unknown Unknown P.0. signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Records, 1 ☐ res 2 ☐ No 3 ☐ Probably 4 ☐ Unknown is certificate has been si director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician; The law autopsy performes 1 Yes **Division of Vital** 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? 1 \sum Yes Other: 4 Nursing Home 5 Residence 2 ANO ည 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) Manner of Deatl 28b. Time of 28c. Injury at work? 1 ☐ Yes Certificate: 28d. Describe how injury occurred After injury Natural 5 Pending n 24 hours after death. e Funeral Director. A sletely filled in by the fi 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check

State

within 2 To the I

only one)

29b. Signature and title of certifier

Name and address of person

Registrar **DHMH 17 Rev 06-2011** Deterse

who completed cause of death (Item 23a) (Type, Print

Regis

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

521

29d. Date signed (Month, Day, Year,

29c. License number

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Marvland / Department of Health and Mental Hygiene 2012 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Year Month Shirley Ann Dabbs 5.16 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Glen Burnie Mone rator Medica Boltimorelybsh g. Birthplace (State or Foreign Country)
Maryland If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8 Date of Birth **Funeral** Months Days 1 🗆 M 2 😿 F Hours Min 217 46 2768 66 (Month, Day, Year) 06/24/1945 **Director** Usual Residence of Decedent 10a. State 10h County 10c. City, Town or Location with the Maryland 10d. Inside City Limits Director 28a-f Marvland Anne Arundel Severn 1 ☐ Yes 2 🔀 No 10e. Street and Number 10g. Citizen of What Country? 0 10f. Zip Code must be Funeral 23a 1669 Shannon O Circle 21144 U.S. Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 X Never Married 2 Married "natural", or Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 A No Specify: White Specify Completed 3 Widowed 4 Divorced er than "natur the Medical I 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 2 years n and Mental Hygiene.

I is marked other than raumatic event, the M Elementary/Seconday (0-12) Northrup Grumman Drafter Be Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Robert Hamilton Dabbs 27 is marked r traumatic e Anna Elizabeth Burke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bonnie Wright / sister Baltimore, Maryland 21225 603 E. Jeffrey Street item 2 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1
Department of I
Important: If it
any injury or o 1 🔲 Burial 2 🙀 Cremation 3 🗆 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) 02/08/2012 Baltimore, Maryland Bavview Crematory 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Gonce Funeral Service, Baltimore, Maryland 21225 4001 Ritchie Highway remular 23a. Hart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** UCPANO Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examine Cause (Disease or linjury that initiated events resulting in death) Last pulmorm the burial-tran Due to (or as a consequence of): attending physician for use as the burial Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) Pregnant at time of death signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tohacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s performed 2 1 No 1 Yes 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner' Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) ျှ 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 24 hours after death. Funeral Director: After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death Medical Certificate: 28b. Time of 28c. Injury_at 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation completed filled in by the 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one) 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) 053703 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CININ SUITORN minim 0 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #20b Per FH G924/2/13/2012 IH State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 202 Rhover Medical 4a. Facility Name (if not institution, give street and num 4b. City, Town, or Location of Death 4c. County of Death **Examiner** abda 115700 N/A Year If Under 24 Hrs. Birthplace (State or Foreign Country) Age (In vrs. last birthday) If Under 8. Date of Birth **Funeral** Days (Month, Day, Year) Months Hours 218-26-5180 1 🗆 M 2 🔀 F **Director** 09/11/1932 Maryland 79 show 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 72 hours after death with the Maryland Director ms 23a or 28a-f s must be notified 1 XYes 2 No N/A Baltimore MD 10f, Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 21207 U.S.A. 2600 Essex Rd. Apt 104 items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Examiner Black, White, etc. ŏ þ 1 Never Married 2 Married 1 ☐ Yes 2 ★No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 🗌 Yes 2 屎 No Specify: Black "natural", 3 Widowed 4 Divorced Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Self Employed Seamstress 12th Grade Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ Viola Rustin Carl C. Franklin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2600 Essex Rd. Apt 104, Baltimore, Chandra Hoard(daughter) 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State 2/07/2012 cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) on-site Crematory Baltimore, MD 21. Signature of Funeral Service Licensee Joseph H. Brown Jr. 2140 N. Fulton Ave., Funeral Home PA Baltimore, MD21 MD21217 ac 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or freart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician/ 1 disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to for as a consequence of death certificate be executed Cause (Disease or injury as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical P.O. Box 68760 IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Month Year Pregnant at time of death 5 Other (specify) Yes ed by the a 1 ☐ Yes ∠ ☐ g ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. been signed be should be det 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 Unknown Division of Vital Records, 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy performe death? director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify 1 Yes မ Inpatient 2 ER/Outpatient 3 DOA funeral Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: iniury 5 Pendina within 24 hours after death.

To the Funeral Director; A completely filled in by the fu Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Continuing Nurse Practitioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and tity 1053850 30. Name and address person who completed cause of death (Item 23a) (Type, Print) Worthwest Chi 31. Date filed (Month, Day, Year) Registrar's Signat State FEB 0 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM# 5 per FH, G924, 2/9/2012, WS
State of Maryland / Department of Health and Mental Hygiene 2012 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day 04: 15A M TEPHEN CILASCO 02 2012 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner <u>Levindale HebrewGeriatric Center</u> Baltimore er 1 Year | If Under 24 Hrs. If Under Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 0082216-58-0082 Days Hours Months Min. 1€M 2□ F 60 MD Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at 1 XYes 2 No MD Baltimore Director n/a 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 6611 Eberle Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 24 No 14. Race - American Indian, "natural", or Items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 24 If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. ģ Specify: African-American 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 Is marked other than 'any Injury or other traumatic event, the Meone. Elementary/Secondary (0-12) College (1-4or 5+) Corrections State of Maryland 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဥ Randolph Glasco Sr. Shirlev Brown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirley A. Belton/Sister 5423 Lynview Avenue, Baltimore, MD 21215 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State KIng Memorial Park 2-13-2012 4 Donation 5 Other (Specify) Woodlawn, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Wylie Funeral Home P.A. of Baltimore Co. 9200 Liberty Road, Randallstown, MD 21133 60 234 Pail. Enter the disease, complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Let only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) TNO+1C **Physician** ENCEPHALOPATHY /Medical Due to (or as a consequence of): Examiner OBSTRUCTIVE CHRONIC PULMOWAR if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospital or Attending Physiclan: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 Probably 4. Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe certificate 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ၉ this Director: After the 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Medical Certification: Injury 1 Natural 5 ☐ Pending investigation* 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours aft

To the Funeral D

completely filled in Descritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 02-07 -2012 10064533 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LEVI MISTE MERREW CIERLATTIC 2434 W. BELVENCELE AVENUE BABATUNDE ATANI SAUTIMORE MD 21215 MI)

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

FEB 0 9 2012

stasco, Stephen

32. Registrar's Signature

park

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ February 2012 10:45 PM Eugene Anthony Gregory Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery 10617 Burbank Drive Potomac 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Hours 185-03-9012 1 🖁 M 2 🗆 F **Director** 97 December 21, 1914 Pennsylvania Usual Residence of Decedent show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits with the Maryland must be notified at Director 28a-f 1 Yes 2 X No Maryland Potomac Montgomery 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? ò 23a 10617 Burbank Drive 20854 United States death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status ral", or iten Examiner Armed Forces?

1 X Yes 2 No 1950—
If Yes, Give Year or Dates. 1969 Black, White, etc. 1 Never Married 2 X Married þ permit. Page 1 and 2 should be filed within 72 hours after. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examin Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Master Sargeant (Specify only highest grade completed) United States Elementary/Secondary (0-12) College (1-4 or 5+) Military Intelligence Armv Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Eugene Gregory Agnes Bierwirth 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eugene W. Gregory / Son 10617 Burbank Drive, Potomac, Maryland 20854 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State March 9, 1 X Burial 2 Cremation 3 Removal from State Department o
Important: If
any injury or
once. Arlington, Virginia Arlington National Cemetery 2012 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Leensee Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. ngelette augh 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 Pat 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician. una ancer disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events Due to (or as a consequence of): Hospital or Attending Physician; The law requires that the death certificate be executed and the burial-trai Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? should be detached for Month Day Year 1 Yes 2 L 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s performed? Yes 2 No safter death.

Director: After this certificate 1 Yes 2 No 25. Was case referred to medical filled in by the funeral director, 26. Place of Death (Check only one) Certificate: To Be Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) 1 ☐ Yes 2 🗶 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1X Natural 5 \square Pending 1 Yes 2 No Accident Investigation 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check

Registrar DHMH 17 Rev 06-2011

State

3

31. Date filed (Month, Day, Year)
FEB 0 9 2012

d titlA of certifier

Geoffrey Coleman, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29c. License number

D37142

1355 Piccard Drive, Suite 100, Rockville, Maryland 20850

29d. Date signed (Month, Day, Year)

February 7, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		For		State o	f Marylan					and M	lental Hy	/giene	÷			
	1	State Registrar				Cert	ificate	of De	eath_			Reg. No	20	12	03578	
Physiciar	,	1. Decedent's Name (First, Mi	ddle, L	ast)							2. Date of Do Month	eath Da	<u>د</u> س	Year	3. Time of Death	
Medica	al .	Thomas Arthu									Februa			012	10:11AM M	
Examine	er	4a. Facility Name (if not institu	tion, gi	ve street and num		4b. City, To			of Death				of Death			
		Shady Grove . 5. Social Security Number		ospital 7. Age (In yrs. Ia	et hirthday)	Rock If Under 1		e If Under 2	24 Hrs.	8. Date of Bi		Montgomery 9. Birthplace (State or Foreign				
Funeral Director		035-15-2099	0.	1 X M 2 □ F	1. Age (III yis. ia	Yrs.			Min.	(Month, D	ay, Year)	011	Country)			
		Usual Residence of Deceder	nt	· x		115.	6 2	20			July 13,		011			
rland F sho	형	10a. State 10b. County			10c. City	, Town or Loca	ation								0d. Inside City Limits	
Man 28a- lotifie	Director	Maryland Mon	tgoı	mery	Roo	ckville									1 🗆 Yes 2 😾 No	
th the	a D	10e. Street and Number					10f. Zip C							What Coun		
ms 2 mus	Funeral	10124 Vander	bil		dent Ever in U.S	12 W	2085		anic Orio	nin? (Sne	cify Yes or No			Stat e - Americ		
or ite	by F	11. Marital Status1 ▼ Never Married 2 □	Marrie	Armed Fo	rces?	If	Yes, specify	Cuban,	Mexican					ck, White,		
s afte		3 Widowed 4 Divo		If Yes, Giv Year or Da	e	1 L Yes 2 L			′es 2				Specify: White			
"natu dical	Completed			Education grade completed)		16a. Decede	16a. Decedent's Usual Occupation (Give kind of work done during most of working					16b. k	(ind of B	usiness/Ind	dustry	
hin 7%	mo	Elementary/Secondary (0-12) College (1-4 or 5+)				life. DO NOT use retired)							n	one		
d with	Be C	17. Father's Name (First, Midd	tlo Las	t)			no		I Mothe	ar'e Name	First Middle	Maiden				
oe file sntal H ced o	2											0)				
ould I		19a. Informant's Name/Relati				19b. Mailing	n Address (S	Street and			l Route Numb			State, Zip C	Code)	
12 sh ulth ar 27 is r trau		Thomas Arthur			ather	1									land 20850	
1 and of Hea item othe		20a. Method of Disposition			20b. P	lace of Dispos	sition (Name	of			uary			- City or To		
Page nent c int: If		1 🛱 Burial 2 □ Crema 4 □ Donation 5 □ Oth			State	Souls	Ceme	tery	1	8, 2	012				Maryland	
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	9	21. Signature of Funeral Serv	ice Lice	ensee	14 110	22.	Name and	Address	of Facilit	y Ro c. 3	bert A	Pur t Mo	nphr ntgo	ey Fu mery	neral Home/ Avenue	
	\dashv	21. Signature of Funcial Service Licensee 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/ Rockville, Inc. 300 West Montgomery Avenue 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between														
Physician/		Immediate Cause (Final	_ist onl			rrhy u.	الم المت	+		c + o	rosnim	town	fail	LA VP	Onset and Death	
Medical	L	disease or condition resulting in death)		a. Due to	hant a	uence (iii):	mia a	40 1	c a	LUIC	respire	HOLY	[oil b	4,0		
Examiner		Sequentially list conditions,		h	80											
	Examiner	it any, leading to immediate Due to (or as a consequence or).														
cuted	xarr	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):														
iath certificate be executed attending physician and I for use as the burial-transit	dical E	resulting in death) Last	- 1	L Buc to	(or do d do nooq	301100 01/1										
cate the physics the l	edic			d												
certifi nding use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant		23c. If yes, out	tcome of pregna	ıncy	1 = 1					ļ	23d. Da	ate of deliv	ery	
eath of atter	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No		Ectopic pregnancy Other (specify)					Mon			Day Year				
the d	hys	9 Unknown														
s that gned be de												ontribute to the cause of death?				
quire sen siç ould l	ted	trisomy 13				1.			_				·		bably 4 Unknown	
law re las be e 2 sh	Completed by	multiple c.	ong	enital 1	naltorn	ations					24a. Wa	as an topsy rformed?	24b.		ppsy findings available empletion of cause of	
The cate I											1 \(\sum \) Ye:	s 2 📈 1	No	1 Yes	2 🗆 No	
ician: certifi rector	Be	25. Was case referred to med examiner?	dical	Hospital:				Other			k only one)					
Phys this eral di	2.5	1 X Yes 2 No 27. Manner of Death		28a. Date	Inpatient 2 🔊	ER/Outpatien 28b. Time of		c. Injury a	4 L N		ome 5 Re 28d. Describe				0	
nding th. : After	cate	1 Natural 5 Pe	ending vestiga	1 '	nth, Day, Year)	injury	М	work?	es 2 🗆			,				
Atter er dea ector by th	Certificate:	3 Suicide 6 C		ot be 28e. Place	e of Injury - At ho		et, factory,	office				(Street a		ber or Rura	l Route Number,	
ital or irs aft al Dir led in																
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi	Medical	Chock 2 Medi	cal Ex	Physician: To the banniner: On the ballurse Practitione	sis of examinatio	n and/or invest	ioation, in m	v opinion	, death o	ccurred a	t the time, date	e and plac	e, and d	ue to the ca	ause(s) and manner stated.	
To th withir To th comp	-		rtifier	1 1	//.			License r				1		ed (Month,		
		1 teple	1	1 olar	1/ms	>		116	5			2	13/	12		
•		30. Name and address of per 5 tephen L N			e of death (Item	1 23a) (Type, P	Cente	r Di	rive	Roc	lon'lle,	Man	Ina	! ~	980	
Stat Registra		31. Date filed (Month, Day, Yo			Registrar's Signa		41				-					
negistra	at	. 20 7		- AND SALES	p.	The same	100									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #19e for Maryland The G924m 2/09/2012 JH Amental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month EBR WAR Physician/ 18:00 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Bayview Med. Center Johns Hopkins IMOR If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 8. Date of Birth 7. Age (In yrs. last birthday) Funeral 216-62-9644 1 🛛 M 2 🗆 F Months Hours Min 08/17/1956 MD **Director** Usual Residence of Decedent 28a-f shov 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland notified at Director XX Yes 2 No BALTIMORE MD 0 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? items 23a or ner must be n Funeral USA 5606 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Deceuc... Armed Forces? 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status d other than "natural", or itel event, the Medical Examiner Black, White, etc. Š 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Tes 2 No Specify: If Yes, Give Year or Dates SpecifBLACK 3 Widowed 4 Divorced Completed Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working should be filed within 72 and Mental Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) MAINTENANCE SUPERVISOR MD. STATE 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည permit. Page 1 and 2 should be Department of Health and Ment. Important: If item 27 is marked any injury or or other. ALTHEA SHORTS **JAMES** GRAVES, JR. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
5606 FORCE ROAD, BALTIMORE, MD 21217 19a. Informant's Name/Relationship (Type, Print) TAMMY J. GRAVES/WIFE 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 02 - 11 - 2011 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place) MARRIOTTSVILLE, MD CREST LAWN MEM GAR. 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC 21. Signature of Funeral Service Licensee 1701 LAURENS ST., BALTIMORE, MD @!@!& 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between VLTIPLE Immediate Cause (Final Onset and Death ORGAN Physician/ 6 hours disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** T17 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Examine attending physician and for use as the burial-tran Due to (or as a consequence of) Physician/Medical The law requires that the death certificate be P.O. Box 68760 as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy hed for t in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown signed by the Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 5 Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 No has within 24 hours after death.

To the Funeral Director: After this certificate 1 Yes 2 No Hospital or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ၉ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work?
1
Yes 28d. Describe how injury occurred 5 Pending injury 1 Natural 2 No Accident Investigation completed filled in by the 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier 1 🗶 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the 29b. Signature and title of certifier RES-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4940 EASTERN AVE

HMH 17 Rev 7/2009

State Registrar Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend # States FRAY 18924 Debath 2014 Tealth and Mental Hygiene

		-	For State Registrar	Cei	rtificate of De	eath	R	eg. No. 2	12	03580				
	Physicia		Decedent's Name (First, Middle, Last) MARY FREDA HALE Mary Fr	ieda Hale			2. Date of Death Month FEB.	4 201	Year 2	3. Time of Death 9:30AM M				
J€ang	Medic Examin		4a. Facility Name (If not institution, give street and number 7662 Gumspring Rd.	r)	4b. City, Town, or Le Baltimor	ocation of Death	4c. Cou		nty of Death Baltimore					
	Funeral Director		·	Age (In yrs. last birthday) 94 Yrs.		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Dec. 28	Year)	Count	lace (State or Foreign ry) yland				
	ryland -f show ied at	ctor	10a, State 10b. County	10c. City, Town or Lo	Baltimore	- County			10	0d. Inside City Limits 1 ☐ Yes 2 X No				
	with the Ma 23a or 28s st be notif	.= L	Maryland Baltimore 10e. Street and Number 7662 Gumspring Rd.		10f. Zip Code	21236	1	0g. Citizen of W	hat Coun					
980	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status 1 Never Married 2 Married 3 Wildowed 4 Divorced 12. Was Decede Armed Force 1 Yes 2 If Yes, Give Year or Date:	X No	Was Decedent of Hisp If Yes, specify Cuban, 1 ☐ Yes 2XXNo		cify Yes or No- Rican, etc.)		, White, e					
1215-0	thin 72 hou ene. than "natu he Medical	Be Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4	or 5+) (Give	dent's Usual Occupati kind of work done dur OO NOT use retired)	ring most of worki	ng	16b. Kind of Bus						
Baltimore, Maryland 21215-0036	d be filed wi Aental Hygis arked other itic event, t	To Be (11 yrs. N/A 17. Father's Name (First, Middle, Last) Nichalos Ramseyer	Sel	Lf⊶Employed	18. Mother's Name Mary Si	(First, Middle, M			004				
Mary	d 2 should alth and N 27 is ma er trauma		19a. Informant's Name/Relationship (Type, Print) Carol A. Hale (Daughter)	19b. Maili 101	ing Address (Street and Walnut Ave	d Number or Rura enue Bal	Route Number, timore,	City or Town, St. Md. 212	ate, Zip C 06	'ode)				
imore,	Page 1 and ment of Hed ant: If item ury or othe		•	y or Town, State e, Md.										
Balt	permit. Departi Import any inj		21. 19 to e of Funeral Service Licensee	2	2. Name and Address 7401 Belai:	of Facility La r Rd. Ba	ssahn Fu ltimore,	neral H Md. 21	ome 236	10				
Jan Jan Jan Jan Jan Jan Jan Jan Jan Jan	Physician/		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Approximate Interval Between Onset and Death											
Medical Examiner			Due to (or Anteru											
	uted d ansit	Examiner	if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	as a consequence of):										
0	ificate be executed ig physician and as the burial-transi	/ledical Ex	resulting in death) Last Due to (or	as a consequence of):										
68760	tificate ng phy e as the	Med	IF FEMALE:											
. Box 6	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director, After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/N	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outco 1 Live Bir 4 Pregna 9 Unknow	e of deliventh	ery Day Year									
Division of Vital Records, P.O.	quires that the consigned by the could be detailed.	by	Part II. Other significant conditions contributing to dea	th but not resulting in the	underlying cause giver	n in Part I.	23e. Did tob			e cause of death?				
Recor	s ician: The law ree s certificate has be director, page 2 sh	Completed					24a. Was ar autops perform 1 \sum Yes 2	med? p		osy findings available impletion of cause of				
/ital	ysician is certifi director	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital:	patient 2 ER/Outpatie	_ Other:	e of Death (Check	only one) me 5 Reside	ence 6 Othe	r (Specify)				
on of \	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,		27. Manner of Death 28a. Date of		28c. Injury a work?		28d. Describe ho							
Division	To the Hospital or Attending I within 24 hours after death. To the Funeral Director, After completely filled in by the funer	Certificate		Injury - At home, farm, steetc. (Specify)	reet, factory, office		28f. Location (Sti City or Town		r or Rural	Route Number,				
	ne Hospit n 24 hour ne Funera pletely fill	Medical	29a. Certifier (Check 2 Medical Examiner: On the basis only one) 3 Certifying Nurse Practitioner: T	of examination and/or inves	stigation, in my opinion	, death occurred at	the time, date an	d place, and due	to the cau	use(s) and manner stated.				
	To t with		29b. Signature and title of contifier		29c. License r	Y10	2	9d. Date signed	Month, I	Day, Year)				
)			Dr. Lya Pfeffer	of death (Item 23a) (Type,	GE RO	BAltin	my Me	212	37					
	Sta Registra		31. Date filed (Month, Day, Year) 32. Reg	istrar's Signature	,									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 0. 0. 1. 0.					
			Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death	3. Time of Death				
	Physicia Medic		Michael J Horne Sr. Pay 201 Year	2200 M				
đ	Examin		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death	a				
-	Funeral	м	5. Social Security Number 6. Sex 7. Age (In we lest hirthday) If Under 1 Year I If Under 24 Hrs 8. Pate of Right In Indian 1 Indian 2 Indian 2 Indian 2 Indian 3 Indi	hplace (State or Foreign				
	Funeral Director			untry)				
	nd how at	'n	Usual Residence of Decedent	10d. Inside City Limits				
	//arylar 8a-f s tified	Director	MD PG Upper Marlboro	1 ▼ Yes 2 □ No				
	a or 20	J Dir	10e. Street and Number 10f. Zip Code 10g. Citizen of What Co	untry?				
	th with ms 23 must	Funeral	9 Cable Hollow Way 20774 USA					
21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	1 Never Married 2 Married 1 X Yes 2 No	e, etc.				
15-0	72 hou "natu edical	Completed	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business I	ndustry				
212	vithin 7 iene. r than the M			Dept. Of Defense				
nd ?	filed val Hyg	Be	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)					
Maryland	uld be I Ment narke natic e	To.	Defait 1. Horie					
Ma	2 sho Ith and 27 is r r traun		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Evelyn V. Lowe/Mother 9 Cable Hollow Way Upper Marlboro, MD 20					
ore,	of Hea of Hea fitem rother		20a. Method of Disposition 20b. Place of Disposition (Name of Competent Com	Town, State				
Baltimore,	Page tment tant: I		A Donation 5 Other (Specify) Riverdale Pk Crem. 2-17-2012 Riverdale,	MD				
Ball	permit Depart Impor any in		21. Signature of Funeral Service License 22. Name and Address of Facility Ronald Taylor II FH 10583 Middleport Ln. White Plains, MI	20695				
			23a. Part 1. Enter the disease, or complications that haused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final	Approximate Interval Between Onset and Death				
	Physician/ Medical	1	disease or condition resulting in death) a. Chronic Lymphoid Teukemia Due to (or as a consequence of):	Offset and Death				
	Examiner	L	Pancytoronia					
	o tit	nine	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): cause: Enter Underlying					
	ecute and Il-trans	Examiner	Cause (Disease or linjury that initiated events c. Due to (or as a consequence of):					
0	ate be executed physician and the burial-transit	edical	d					
68760	rtificating ph							
Box 6	ath certific attending p	cian/	23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3 Ectopic pregnancy 23d. Date of deli					
). B	Attending Physician: The law requires that the death certificate be executed as death. sctor. After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	1 Yes 2 No 9 Unknown 9 Unknown					
P.O.	s that igned b	þ	23e. Did tobacco use contribute to					
of Vital Records,	require been si should b	Completed	1 Yes 2 No 3 Pr					
eco	e law n has b ge 2 sh)du	24a. Was an 24b. Were aut prior to contact the contact that the contact th	opsy findings available completion of cause of				
E E	ician: The la certificate ha ector, page			2 No				
Vita	hysici nis cer I direc	일	1 Yes 2 No Prospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Special	fy)				
n of	ding Ph h. After th funeral	ate:	27. Manny of Death 1 Natural 5 Pending 28a. Date of injury (Month, Day, Year) 28b. Time of injury at work? 28b. Time of injury at work?					
Division	il or Attendi safter death. Director: A d in by the fu	Certificate:	2 Accident Investigation M 1 Yes 2 No No No No No No No No	al Route Number				
Divi	tal or is after al Direction bed in b							
	To the Hospital or A within 24 hours after To the Funeral Dire completed filled in b	Medical	29a. Certifier (Check (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated to the cause (s) and manner as stated and place, and due to the cause (s) and due to the cause (s) and	ause(s) and manner stated.				
	To the within 2 To the comple	ž	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month					
	->-0		Docelyne Kouatchou, mD D63748 2/6/13	>				
	/ 1		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)					
	V €		Dr. Jocelyne Kouatchow 4041 Powder Mill Rd #600 Calverton, MD 20705 31. Date filed (Month Pay Year) 32. Figistrar's Signature					
	Stat Registra	e Ir	31. Date filed (Month Car Year) 9 2012 32. 5 gistrar's Signature					

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year 2012 Day Henson Edna **Physician** MATY /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner Baltimore City** NA The Johns Hopkins Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 M 2 X 218-22-3404 05-01-26 Director 85 MD Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County XXYes 2 No **Funeral Director** must be notified Baltimore · 28a-f MD NA 10g. Citizen of What Country? 10f. Zip-Code 10e. Street and Number ō 1521 N. Luzerne Avenue 21213 USA Pages 1 and 2 should be filed within 72 hours after death 14. Race - American Indian, Black, White, etc. African Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: American þ 3 X Widowed 4 □ Divorced is marked other than "natural", aumatic event, the Medical Exa Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Baltimore City mentary/Secondary (0-12) College (1-4 or 5+) and Mental Hygiene. School System 12th Grade Food Services NA 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles Η. Bell Anna Warren ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other trai once. 1521 Beverly Lewis-Daughter N. Luzerne Avenue Baltimore MD 21213 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State King Mem. 4 Donation 5 Other (Specify) 02-14-12 Randallstown, MD 22. Name and Address of Facility Wylie Funeral Home P.A. 21. Signature of Funcial Service Licensee 638 N. Gilmor Street Baltimore, MD 21217 234 Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final neumonia **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant Live birth 2 Fetal death Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Division of Vital Records, 2 No 3 Probably 40 Unknown 1 Yes Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 **X**No 1 Tyes 25 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2X €R/Outpatient 3 □ DOA Medical Certification: To Manner of Death 1 Natural 2 Accident 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Yes 2 No Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Do66619 and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

Box 68760.

P.O.

600 North Wolfe St, Baltimore, MD, 21287

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 20 | 2

			For State Registrar		State of Ma	aryland			nt of F e of C		nd M	-	giene _{Reg. No}	an 20 8	2	0358	3
h	Physicia	en/	1. Decedent's Name	e (First, Middle, Last)	1							2. Date of De Month	ath			3. Time of Death	
	Medic Examin	cal		ee Harwel				4b. City, Town, or Location of Death						y 201 County of E		10:45 P	M
	LAdillii	ICI	607 University Blvd. W Silver Sp											ntgom	ery		
	Funeral Director		5. Social Security No. 321–52–0 Usual Residence of	828 1	7. Age	e (In yrs. la 56	st birthday) Yrs.	If Unde Months	Days	If Under 24 Hours	4 Hrs. Min.	8. Date of Bir (Month, Da Oct. 4	v. Year)	1	Counti	ace (State or Forei y) nois	gn
	/land f show ed at	tor	10a. State	10b. County		,	, Town or Loc								10	d. Inside City Limi	
	r 28a-	Direc	MD 10e. Street and Nun	Montgomer	У	Silv	er Spr		p Code				10a Cii	tizen of Wha	t Count	1 \(\text{Yes 2 \(\text{X} \)	No
	with th	Funeral Director		ersity Blv	d. W			209					USA	iizeii oi vviia	COunt	ıy:	
36	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status 1 Never Marr	ied 2 X Married	2. Was Decedent E Armed Forces? 1 Yes 2 X If Yes, Give	ver in U.S No	l I	f Yes, spe	cify Cuba	spanic Origin n, Mexican, I Specify:	n? (Spec Puerto R	ify Yes or No- lican, etc.)		14. Race - A Black, V Specify: B	Vhite, e	tc.	
5	hours natura lical Ex	Completed	3 Widowed	15. Decedent's Edu	Year or Dates.		16a. Deced	lent's Usi	al Occupa	ation				ind of Busin			
121	hin 72 ne. than "r	omb	(Spe Elementary/Seco	ondary (0-12)	College (1-4 or 5	+)	life. D	O NOT us	e retired)	luring most o	of workin	g					
7 0	Hygie Other ent, th	Be	17. Father's Name (First, Middle, Last)	2+		Homen	aker		18. Mother	's Name	(First, Middle,		1 Home Surname)			
ylan	d be fi Mental arked atic ev	으	Ireland (O'Brien Ke	e		_			Thelm	na Jo	ones					
Baltimore, Maryland 21215-0036	nd 2 shoul ealth and m 27 is m		John Ste	ame/Relationship <i>(Typ</i> ven Harwel		Ē						Route Number					
Imore	Page 1 al ment of H tant: If itel iury or oth			oosition X Cremation 3 F 5 Other (Specify)	Removal from State	Fin	lace of Dispo emetery, cren al Jou	sition (Na natory or Irney	me of other plac Crei	natory	7 02/	^{ate} /08/12		ocation - Cit odbine	•		
Ball	permit Depart Import any in		Bu	neral Service License	elite	MO1	251 Bc	verl	v I.	Heckr	otte	Servi	-cla	P.O.	Box	784 MD 2101	20
			23a. Part 1. Enter t shock, or hea Immediate Cause (the disease, or compli rt failure. List only one	cations that caused cause on each line	the death	n. Do not ente	er the mo	de of dying	g, such as ca	ardiac or	respiratory ar	rest,			Approximate Interval Between Onset and Death	
	Ph _y sician/ Medical		disease or condition resulting in death)		Lung Car		ence of):								+		_
San oran	Examiner	<u>.</u>	Sequentially list co	nditions, b													
	nsit	Examiner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury														
	icate be executed physician and is the burial-transit	Ex	that initiated events c. Due to (or as a consequence of):														
09/	certificate be nding physici use as the bu	edical			l												
P.O. Box 68/	certif nding use a	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 conths? 1								230			3d. Date of delivery Month Day Year			
0	at the		9 Unknown Part II. Other signif	ficant conditions con		ut not resi	ulting in the u	ınderlying	cause giv	ven in Part I.		23e. Did t	obacco i	use contribu	te to the	e cause of death?	
	requires that the death been signed by the atte should be detached for	ed by										1X	Yes 2	□ No 3 [☐ Prob	ably 4 🗌 Unkno	wn
Division of Vital Records,	he law requ te has beer age 2 shou	Completed										24a. Was auto perfo	psy ormed?	prio: deat	r to con th?	sy findings availab npletion of cause o	
<u>ta</u>	cian: T ertifica ector, p	Be C	25. Was case referre	li li	ospital:					ace of Death	(Check		2 0,200	<u> </u>			7
<u> </u>	Physic r this c eral din	2	1 Yes 2	X IVO	1 Inpati		ER/Outpatier 28b. Time of	-	Othe 28c. Injury	4 ∐ Nur		ne 5X Resi 8d. Describe l			Specify)		
ouo	ath. r: After	icate	1 🔀 Natural 2 🔲 Accident	5 Pending Investigation	(Month, Day		injury	М	work		- 1	34. 50001150 1	iow ingui	, 000000			
DIVISI	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	al Certificate:	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could not be determined	28e. Place of Injubuilding, etc			eet, facto	ry, office		2	28f. Location (City or Tov			r Rural	Route Number,	
	the Hospi nin 24 hou the Funer npletely fil	Medical	(Check 2 only one)	Certifying Nurse	cian: To the best of er: On the basis of e Practitioner: To th	xamination	and/or inves	tigation, ir	n my opinic	on, death occ	urred at	the time, date a	and place	, and due to	the cau	se(s) and manner s	tated.
	Veith		29b. Signature and	title offertifier	20	6			lc. License 54378					te signed (M uary			
	•		30. Name and addr	ess of person who co	npleted cause of d	eath (Item	23a) (Type, F	-								•	
			Cheryl A	ylesworth,	M.D. 273	30 Un	iversi		lvd.	#400	Whea	ton, M	D 20	902			
	Sta	te	31. PEB-0/09	"2012" (Zen	32. Regultra	ar's	- Co										

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ $20\overset{\scriptscriptstyle{ ext{Year}}}{12}$ \mathbf{P}^{M} February 8:21 Cordelia Barbara Hanson Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Elkridge Howard 6189 Rockburn Hill Road Birthplace (State or Foreign Country) 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** Hours Director 216-16-2593 1 □ M 2 🏋 88 Aug. 20, 1923 Maryland Usual Residence of Decede 3a or 28a-f show t be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 💢 No Maryland Elkridge Howard 10f. Zip Code 10g. Citizen of What Country? ural", or items 23a o I Examiner must be Funeral 6189 Rockburn Hill Road 21075 United States 'natural", or items 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 X No Maryland 21215-0036 1 ☐ Yes 2 😾 No Specify Specify: White 3 x Widowed 4 □ Divorced Completed Year or Dates event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Own Home 12 uth and Mental Hygien 27 is marked other the traumatic event, the Home Maker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph L. Bertha I. Ward Kearney 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 319 Quail Pointe Rd., Knoxville, TN 37934 Walter E. Hanson, Jr./Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2 【 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc 02/09/2012 Baltimore, Maryland 21. Signature of Funeral Service Licensee Alyson K Taylor 22. Name and Address of Facility Cremation Society of Maryland 299 Frederick Road, Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ATHEROSCLE ROTIC CARDIOVASCULAR YEARS disease or condition Medical resulting in death) **Examiner** MELLITUS TEAKS YPE II DIABETES Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): YEARS HYPERTENSION Cause (Disease or injury that initiated events Due to (or as a consequence of resulting in death) Last physician s the buria Physician/Medical Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IE EEMALE 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 9 Unknown P.O. | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ PARKINSON'S DISEASE Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed HISTORY OF BREAST CANCER 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Jas autopsy HISTORY OF CEREBRAL INFARCTION performe death? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?

1 Yes 2 No 26. Place of Death (Check only one) Be ဂ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🗷 Natural 5 Pending after death Director: A d in by the f Accident
Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined within 24 hours a To the Funeral D Medical 1 🗴 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State

5808 MAIN STREET ELKRIDGE, MD 21075 M.D. FEB 0 9 2012 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mys

bown lum

29b. Signature and title of certifier

Registrar

D ZZ83Z

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #20b Per FH G924 / 2/14/2012 III State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2012 William Douglas Houser February 11:10P Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Bethesda Montgomery Sunrise at Fox Hill Social Security Number 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** (Month, Day Days Hours Min. 1 💢 M 2 🗆 F Months Yrs. Director 90 1921 Georgia 261-18-2325 Nov. Usual Residence of Decedent or 28a-f show 10a. State 10b. County 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 XXVo Virginia Middleburg Loudoun 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 37689 Lime Kiln Road 20117 United States 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 X Yes 2 \(\sigma\) No \(1941 - \) Black, White, etc. 1 Never Married 2 Married δ Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Specify: White 3 Widowed 4 Divorced Completed 1976 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Officer United States Navy Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Harry M. Houser Berenice Horton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $33767\,$ 1 and 2 s of Health item 27 i 880 Mandalay Avenue, #C1214, Clearwater Beach, FL Jan A.K. Evans/Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State unk Date permit. Page 1 a Department of H Important: If ite cemetery, crematory or other place Arlington National Cemetery 1 X Burial 2 Cremation 3 Removal from State ò 06/28/2012 4 ☐ Donation 5 ☐ Other (Specify) Arlington, Virginia 22. Name and Address of Facility Robert A. Pumphrey Funeral Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850-2805 Pumphrey Funeral Home/ 21. Signatura o Toneral Service Live M00803 Rockville. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Days disease or condition Pneumonia Medical resulting in death) Due to (or as a consequence of) Examiner Mixed Dementia Years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this management of the Funeral Director After this management. the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 use as 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗌 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by been signe should be c Coronary Artery Disease 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s performed Yes 2 \(\bar{\Lambda}\) 2 No 1 Yes 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Living Hospital: 1 Tes 2 X No 은 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) . Manner of Death 28b. Time of 28c. Injury at work?
1 Yes 2 No Certificate: 28d. Describe how injury occurred 5 Pending injury 1 X Natural Accident
Suicide Investigation completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one

DHMH 17 Rev 7/2009

State

Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day,

Patricia Tomsko Nay,

FEB 0

Year)

30. Name and address of person who completed cause of geath (Item 23a) (Type, Print)

M.D.

Registrar's Signature

29c. License number

D51916

11119 Rockville Pike, G-100, Rockville, MD

29d, Date signed (Month, Dav. Year) February 6, 2012

20852

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 7 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 3, 2012 Physician/ 7:04 P M February Cecilia Μ. Holtman Medical 4a, Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner **Baltimore** Towson Gilchrist If Under 1 Year Months Days If Under 24 Hrs. Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) Social Security Number 6 Sex **Funeral** Months Director 213-03-4238 1 🗆 M 2 🗓 F Maryland 7/6/1917 10d. Inside City Limits 10c. City, Town or Location 10h County Page 1 and 2 should be filed within 72 hours after death with the Maryland notified at Director 1 Yes 2 No 28a-f Baltimore Towson Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5 must be Completed by Funeral U.S.A. 21204 apt 1404 615 Chestnut Ave. d other than "natural", or items event, the Medical Examiner mu 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 X Never Married 2 Married White Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify: 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Education Elementary/Secondary (0-12) College (1-4 or 5+) Teacher 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) item 27 is marked other traumatic ev 2 Isabelle Trageser Joseph Holtman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) William J. Glaccum / Nephew 3533 Madonna Lane Bowie, Maryland 20715 20c. Location - City or Town, State 20a Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of h
Important: If ite
any injury or ot cemetery, crematory or other place) 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Towson, Maryland 2/8/2012 Hilltop Serv. Corp. 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. Towson, Maryland 21204 1050 York Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Esqueritiany list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last nding physician and use as the burial-tra Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant ☐ Ectopic pregnancy ☐ Other (specify) ____ Day Month in the past 12 months?

1 Yes 2 No Pregnant at time of death Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy perform 2 🗆 No Yes 1 Tyes 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? 1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 힏 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ral Director. After th 28c. Injury at work? 1 ☐ Yes Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 1 Natural
2 Accident
3 Suicide
4 Homicide iniury 5 Pending 01/201 un known Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 15 CHES MUT AU & Towson, MD 21204 determined Home within 24 hours a

To the Funeral C

completely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Physician: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29 rtifler (Check only on 29c. License number 29d. Date signed (Month, Day, Year) of certifier Signa D0071287 ad address of person who completed cause of death (Item 23a) (Type, Print)

Completed Cause of death (Item 23a) (Type, Print)

Completed Cause of death (Item 23a) (Type, Print)

Completed Cause of death (Item 23a) (Type, Print)

State Registrar 32. Registr

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. end #2,820b&C Per PHY &FH 9924 2/14/2012 JH State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death of Death7 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ T-50 M Medical 4a. Facility Name (inot institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 9114 Road Baltmore handalistown OWER If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 037.24.3807 Hours Director 1 X M 2 □ F 03/08 Yrs. 1941 28a-f show 10b. County 10d. Inside City Limits death with the Maryland at 10a, State 10c. City, Town or Location Director notified MD Baltimore Randallstown 1 Tes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number ö Examiner must be 23a Funeral 21133 USA 9114 Tower Koad items 2 Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11, Marital Status Was Deceden... Armed Forces?... 1 Yes 2 No Black, White, etc. P by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 72 hours after 1 Yes 2 No Specify: Black If Yes, Give Year or Dates "natural", 3 Divorced 4 Divorced Completed permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturally injury or other traumatic event, the Medical Inoce. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Keligion Ministerial Legal Advisor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ SOM 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Num er, City or Town, State, Zip Code) Kandallstown MD son Koad 20c. Location - City or Town, **Baltimore, Md** 20a. Method of Disposition 20b. Place of Disposition (Name of Arrhut usna Memore of Date 1 Burial 2 Cremation 3 Removal from State 02 11/2012 4 ☐ Donation 5 ☐ Other (Specify) MIMASON Yaughn C. Eineene Funeral Services Signature of Funeral Service License Varie Kandallstown MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset a Death Immediate Cause (Final Provician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any leading immodes cause. Enter Underlying Examine Due to or as a consequence of Cause (Disease or injury that initiated events resulting in death) Last executed -tran pug Due to (or as a consequence of): burial attending physician I for use as the buria Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 - Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) Pregnant at time of death signed by the at Id be detached fo Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ ک Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has I autopsy performed? Yes 2 No within 24 hours after death.

To the Funeral Director: After this certificate I completely filled in by the funeral director, pag 2 🗌 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 KR Residence 6 Other (Specify) Hospital 2 No 은 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) State Registrar

2-01092	Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2012	035
Raymond E. Johnson	State of Maryland / Department of Health and Mental Hygiene	
	- 1187 A	

		- For State		Cert	ificate of	Death			Re	g. No.		
Physicia Medical Examin	n/	Decedent's Name (First, Middle,Last		Edmor	nd Ioh	nson			Date of Death Month ebruary 6	Day Year	3. Time of Deat 0815 hrs	th
yledical Examin		4a. Facility Name (if not institution, give	9	Edinoi			wn, or Location		-ebruary 6	4c. County o	f Death	
		Prince George's Hospital	,	Cheverly						eorge's		
Funeral		5. Social Security Number 6. Se	x 7. Age	(In yrs. las	st birthday)	If Under		rs Min			Birthplace (State or Foreign	
Director		213-36-7401 1X	M 2 F	70_	Yrs.	IVIONITIS	Bayo Hear		March	6, 1941	country)Mary1	.and
any	-	Usual Residence of Decedent 10a. State 10b. County		Oc. City, 7	Town or Locati	on					10d. Inside City	y Limits
		MD Prince G	eorges			Uı	per Mar	lboro			1 Yes 2	No
arylan 8a-f si	Director	10e. Street and Number		_		10f. Zip				g. Citizen of Wh	at Country?	
the M a or 2		5 Braswell Cour	t				20774			USA		
sath with the Maryland items 23a or 28a-f show ust be notified at once.	Funeral	11. Marital Status 1 Never Married 2 XMarried	12. Was Decedent E Armed Forces?	ver in U.S			t of Hispanic Or Cuban, Mexica			14. Race White	 American Indian, Blac etc. 	⊧k,
r deat			1 X Yes 2 1 Yes, Give Year 19	ີ ∾ ໂ8 –1 9	967 1 Yes 2 X No specify:			v.		Black		
ırs afte	화	15. Decedent's Education (Specify or		16a. Deceden	's Usual C	ccupation (Give	e kind of wor		Specify: 16b. Kind of Bus			
72 hor	Completed	Elementary/Secondary (0-12)	College (1-4 or 5-	+)			ing life. DO NO	I use retired	1)			}
vithin ene.	g .		2		Driver 18.Mother's Name				irst Middle N		ortation	
filed of Hyg	Be Co	17. Father's Name (First, Middle, Last) Harry			Johnson					ae	Cromwe11	
212 212 Muld be Menta mark	8	19a. Informant's Name/Relationship (T	ype, Print)				(Street and Nu				n, State, Zip Code)	
MD 12 sho th and 127 is umati		Joanne M. Johnson	n, wife				Court	-		rlboro,		
Baltimore, MD 21215-0036 bermit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "matural", or items 23a or 28a-f abo injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 Burial 2 X Cremation 3	Removal from Stat		lace of Dispos rematory or oth	ition (Nam ner place)	e of cemetery,		Date		City or Town, State	
imo Page ment c		4 Donation 5 Other Specify:		Met	ro Crei	nator	y, Inc.		08/12		more, MD	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 37 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licen	See George	MacNa			cederic			l Society 1timore		1C.
Physician	+	23a. Part I. Enter the disease, or comp	lications that caused t	he death.								Interval
Medical Examiner		failure. List only one cause on ea Immediate Cause (Final disease a.	cn line. Hypertensive Ath	neroscle	erotic Cardi	ovascul	ar Disease				Death	
_xammer .			Due to (or as a conse	quence of)):							
	ē	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):										
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of):										
Tansit and AOI	Ĕ	events resulting in death) Last d.			·	_						
760, cate be executed physician and he burial - transit	Medical	UNPENDED	AMENDED								-	
1 th 1 th 1 th 1 th 1 th 1 th 1 th 1 th		IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcom	e of pregn		tal death	3 Fctor	pic pregnanc	tv.	23d. Date of Month		ear
Box 687 e death certific the attending ped for use as the	Physician	past 12 months?	4 Pregnant at t	ime of dea	ath =	her (Spec						
Box ne death the atte	hys	1 Yes 2 No 9 Unknown	9 Oliviowii	hut not so	autia in the c	n dock in a	oguso givon in l	Port I	23e Did to	nbacco use contri	bute to the cause of de	ath?
P.O. that the med by detacl	J.	Part II. Other significant conditions Diabetes Mellitus	contributing to death	but not re	sulling in the t	inderlying	cause giverriiri	raiti.			Probably 4 🗸 Uni	
ds, equires		Diaboteo Monitao							24a. Was		Were autopsy findings a	
COL	Completed	-	-				-			rmed?	orior to completion of ca death? Yes 2	
- Re		25. Was case referred to medical				2	6.Place of Deat	th (Check on		2 110		
Vita ysicia this ce	To Be	examiner? 1 ✓ Yes 2 No	lospital: 1 Inpatier	nt 2 🗸	ER/Outpatient		OA Other			Residence 6		
n of ling Pl After funeral		27. Manner of Death 1 Natural 5 Rending	28a. Date of Injur (Month, Day,Ye	ry ear)	28b. Time of I	njury 2	8c. Injury at Wo	_	8d. Describe I	how injury occurr	ed	
SiOr Attend death death sy the	catic	2 Accident Pending Investigat	on 28e. Place of Inj	ury - At ho	me farm stre	et factory			8f. Location (S	Street and Numb	er or Rural Route Numb	per, City
Division of Vital Records, P.O. ral or Attending Physician: The law requires that the start death. **I Director: After this certificate has been signed by led in by the funeral director, page 2 should be detace.	Certification:	3 Suicide 6 Could not determine	be	u., 7	, 12,	-,,			or Town, S			
Hospi 24 hou Funer		29a. Certifier 1 Certifying Physic	ian: To the best of my	knowledg	ge, death occur nd/or investiga	rred at the	time, date and p	place, and di occurred at t	ue to the caus	se(s) and manner and place, and d	as stated. lue to the cause(s)	
To the within To the comple	Medical	29b. Signature and title of certifier	and manner stated.				License numbe				ed (Month, Day, Year)	
		Par	- Holle	رسه			O.C.M.E.			February 7	, 2012	
241		30. Name and address of person who		eath (Item	23a)							
3		Patricia Aronica-Pollak MI		- Ot			Baltimore S	Street, Ba	itimore, M	ບ 21223		
St Regis	ate	31. Date FEBOTO, 9/2012	32. Registrar	s nignatu	facel							

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM# 1 perpHYS, G938, 47272013, WS
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 7 . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Judy Jones Sarvis Judy Jones Jarvi Month 02 2012 Physician/ 3:11 PM 0 Medical 4a, Facility Name (if not institution, give street and number) 4c. County of Death Town, or Location of Death Examiner Baitimore Huspita esegale Year If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthdav) If Under 8. Date of Birth **Funeral** Hours Min 220-12-4847 Director 1 🗆 M 2 🔀 F 86 11/25/1925 Maryland Yrs Usual Residence of Decede or 28a-f show death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 No Maryland Baltimore Essex 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 1431 Galena Road 21221 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2XXNo If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. ō þ 1 Never Married 2XXMarried Maryland 21215-0036 within 72 hours after 1 Yes 2XXNo Specify: Specify. "natural", Completed 3 Widowed 4 Divorced White Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Manufacturing Machine Operator Be Page 1 and 2 should be filed ment of Health and Mental Hyg 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Carl Jones Ethel Flynn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trauonce. 1429 Galena Road, Baltimore, Maryland 21221 David Sarvis, Jr. (Son) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 02/10/2012 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Gardens of Faith Signature of Funeral Service Licensee 22. Name and Address of Facility
Bruzdzinski Funeral Home, P.A. 1407 Old Eastern Avenue, Essex, Maryland a ... Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, spock, or heart failure. List only one cause on each line Approximate Interval Between rediate Cause (Final Onset and Death Physician/ spiratory Dercapnic sease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner (or as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events neumonia the burial-tran and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☑ No Month Day Year Pregnant at time of death the 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Myocardial Interction Non ST-Elevation 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 1 🔲 Yes 24b. Were autopsy findings available prior to completion of cause of death? Dementia 24a. Was an autopsy performed Yes 2 within 24 hours after death.

To the Funeral Director; After this certificate 2 🗌 No 1 Yes 25. Was case referred to medical filled in by the funeral director, 26. Place of Death (Check only one) Certificate: To Be examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗹 Inpatient 2 🗆 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 1 🗹 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No М Investigation 2 Accident 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0063176 2012 MI En Name and address of person who completed cause of death (Item 23a) (Type, Print)

On Chienyenwa Nwachinemere 9000 Fran 9000 Franklin Square Drive halto. 32. Registrar's Signature 31. Date filed (Month, Dav. Year) State FEB 0 9 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 3:00 Aм 2/3/201 Kenneth Melvin Jones Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 6211 Golden Ring Rosedale Baltimore Rd. If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number . Age (In yrs. last birthday) If Under 1 Year **Funeral** Months Days Hours Min (Month, Day, Year) 258-68-6235 1 X M 2 □ F **Director** 69 5/16/1942 Yrs MD Usual Residence of Decedent 23a or 28a-f show 10d. Inside City Limits at 10a. State 10b. County 10c. City, Town or Location Director Examiner must be notified 1 Yes 2 X No MD Baltimore Rosedale 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 6211 Golden Ring Rd. 21237 USA , or items hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces?

1 X Yes 2 No
If Yes, Give Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: Specify: Black "natural", 3 Widowed 4 Divorced Completed Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Decedent's Education (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Mail Carrier U.S. Post Office N/A Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ permit. Page 1 and 2 should be Department of Health and Ments Important: If Item 27 is marked Harry Jones Addie Roles 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Kevin Jones-Son B504 Rosekemp Ave. Baltimore, MD 2<u>1214</u> injury or other Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 2/10/2012 OwingsMills, GarrisonForest 22. Name and Address of Facility March F/H East 1101 E. 21. Signature of Funeral Service Licensee any Ssans North Ave. Baltimore, MD 21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate and Death MOCARdia Immediate Cause (Final Physician/ disease or condition Medical resulting in death) or as a consequence of): Examiner 5equeritary list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events sician and burial-trans Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death Physician/ 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death ed by the a g Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? n signed t þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 N 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 2 No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this completely filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 Tyes Accident Investigation 24 hours after deat Funeral Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F 29b. Signature and title of certifier 29d Date signed (Month, Day, Year) leted cause of death (Item 23a) (Type, Print)

106 Philode (Iha

DHMH 17 Rev 06-2011

State Registrar 32. Registrar's Signature

JENKINS, RICKINGD Baltimore, Maryland 21215-0036

P.O. Box 68760

Division of Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Joseph Richard Jenkins 10:26 February Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore <u>Greater Baltimore Medical</u> Cent Towson 9. Birthplace (State or Foreign Country) 8. Date of Birth 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. **Funeral** Months Hours (Month, Day, Year) 214-20-5291 **Director** 1 X M 2 🗆 F 85 Feb. 16, 1926 Maryland 28a-f shov 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits notified at Director 1 Yes 2 X No MD. Timonium Baltimore 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country Medical Examiner must be 23a Funeral 21093 USA 1 Dalecrest Court #102 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 X Yes 2 No If Yes, Give Year or Dates. Black, White, etc. "natural", or þ 1 Never Married 2 X Married 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 Widowed 4 Divorced Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) the Paper Co. Sales Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F မ Department of Health and Menta Important: If item 27 is marked any injury or other traumatic evonce. George Simms Jenkins Louise Queen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jennifer Butler/ Niece 2161 Asti Court Naples, FL. 34105 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 x Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest Va. 2-15-12 Owings Mills, MD. 22. Name and Address of Facility Ruck Towson Funeral Home, 21. Signature 1050 York Rd. Towson, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Immediate Cause (Final Onset and Death Plysician/ disease or condition Medical resulting in death) Due to (or as a consequence Examiner Respiratory arrest Sequentially list conditions, if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Secondary to Methotres burial-transi and Due to (or as a cor ending physician are use as the burial Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be to thours after death.

Funeral Director: After this certificate has been signed by the attending physicis nding 1 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year signed by the at Id be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed been si should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performe 2 🗌 No Yes 2 X N 1 Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 1 Yes 2 No ပ 1 X Inpatient 2 - ER/Outpatient 3 - DOA 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the 1 within 2 To the 1 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 70806 02/08/2012 Telie the 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State Registrar MD

32. Registrar's Signature

cheikh

Elie

GBMc hospital, Maryland

Patient Known as Almeta Johnson

			Please	Type or Pr								egible.		
	1	For State Registrar		State of M	laryland		artment of tificate of				giene Reg. No. 2	012	03	592
Physician/	/	1. Decedent's Name	e (First, Middle, Las		00		ates			2. Date of De Month	ath	4 Jus	3. Time of 3:5	
Medica Examiner		4. City Taylor of postin of postin								C.71	inty of Death	A		
Funeral	- 1	. Social Security N	umber 6. Se	ex 7. A	ge (In yrs. la	st birthday)	If Under 1 Ye Months Day	ar If Unde	er 24 Hrs.	8. Date of Bir (Month, Da		g. Birt	hplace (State o	r Foreign
Director ≥		Z18-28- Usual Residence of	of Decedent	□ M 2 □ F	77	Yrs.				4-3	0-33		NJ	
or 28a-f sho	Director	M D	10b. County			, Town or Lo							10d. Inside Ci	ty Limits
The Mg a or 28 be notified		10e. Street and Nun	nber		^	200111	10f. Zip Cod	1216			10g. Citizen	_	untry?	
eath with	runeral	7008	Bonne	12. Was Decedent		i. 13. V	Was Decedent of f Yes, specify C			cify Yes or No-	14.1		rican Indian,	
ter of the limit o	2	1 ☐ Never Marr 3 ☑ Widowed	ied 2 Married	Armed Forces' 1 Yes 2 If Yes, Give Year or Dates.		- 1	Yes, specify C	/		nicali, etc.)	Spe	Black, White		-
215-0036 in 72 hours after e. nan "natural", o	Completed		15. Decedent's E	ducation		(Give	dent's Usual Ockind of work do	ne during mo	ost of workir	ng		of Business/		- 1
within 7 giene.		Elementary/Seco	ondary (0-12)	College (1-4 or	5+)	life. D	O NOT use retir				1+	-ospi	tal	
laryland 212 should be flied within and Mental Hygiene. is marked other tha aumatic event, the 1	To Be	17. Father's Name (Boone	>					e (First, Middle, ^e Le				
		19a. Informant's Na	ame/Relationship (7	ype, Print)			ng Address (Stre	eet and Num	ber or Rura	l Route Numbe	er, City or Tow	n, State, Zip		- 8
ore, N of Health of Health fitem 27 rother tr		20a. Method of Disp	position /	/ Daugh	20b. P	lace of Dispo	O Leh esition (Name of matory or other)			, Bal) Date			Town, State	<u> </u>
Baltimore, Baltimore, permit. Page 1 and Department of Her Important: If item any injury or othe		4 Donation	5 Other (Special		Go	uri30	n Fones	+VA	2//	6/12	Owing	5 Mil	11s, Mr)
Bal Berni Depar Impo any ir		1/1/	neral - rvice Licen				2. Name and Ad					D 212	06-51	05
- WWilliam		23a. Part 1. Enter t shock, or hea Immediate Cause	art failure. List only o	plications that causone cause on each li	ed the death ne.	h. Do not ent	er the mode of o	dying, such a	as cardiac o	r respiratory a	rrest,		Approxima Interval Bet Onset and	ween
Medical Examiner	İ	disease or condition resulting in death)		a. Due (or a	3 (/cs a consequ	uence of):	1/2	71/	8-5	<i>a</i>				
		Sequentially list co if any, leading to in- cause. Enter Unde	onditions,	b. His to (or s	e di di di di di di	andw affi								
executed an and rial-transit	Examiner	cause. Enter Unde Cause (Disease or that initiated event resulting in death)	injury ts	c. Due to (or a	s a consequ	uence of):								
⊕ <u>E</u> ≝ 6	- 1	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		d										
Box 68760 death certificate be. he attending physici	n/Me	IF FEMALE: 23b. Was decedent	t pregnant	23c. If yes, outcom	e of pregna	incy	Trabala and				23d	. Date of de	livery	
Division of Vital Records, P.O. Box 68760 for the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the bu	Pnysician/Medica	in the past 12 1 Yes 2 9 Unknown	months? ☑ No	4 Pregnant 9 Unknowr	at time of c		Ctopic pregr					Month	Day	Year
P.O. BC				contributing to death	but not res	sulting in the	underlying caus	e given in Pa	art I.				the cause of o	
rds, requires been sign should the	leted	HM	Cantel	ý S						24a. Was		4b. Were au	robably 4 X	available
Division of Vital Records, all or Attending Physician: The law requires s after cleath. In Director: After this certificate has been signed in by the funeral director, page 2 should be an in by the funeral director, page 2 should be a second to the funeral director.	Completed by	Lung	CANUI							perf	opsy ormet? 2 No	death?	completion of o	cause of
/ital sician: certific	lo Be	25. Was case referrexaminer? 1 Yes 2	red to medical	Hospital:	atient 2 🗹	FR/Outpatie		Other:		ome 5 Res	idence 6 🗍	Other (Spec	cify)	i i
n of / ing Phy After this funeral o		27. Manner of Deat	5 Pending	28a. Date of in (Month, E	ijury	28b. Time o injury	f 28c. I	njury at work?		28d. Describe				
isior Attend er death ector: A by the 1	Certificate:	2 Accident 3 Suicide 4 Homicide	Investigatio 6 Could not independent in the determined	be 28e. Place of I	njury - At ho		M reet, factory, off				(Street and No	umber or Ru	ıral Route Num	ber,
Division of Vital Rec To the Hospital or Attending Physician: The la within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page		29a. Certifier	1 🗷 Certifying Phy	vsician: To the best	of my know	ledge, death	occurred at the	time, date a	ınd place, a	nd due to the	cause(s) and r	nanner as s	tated.	
the Hos	Medical	(Check only one)	3 Certifying Nui	niner: On the basis or rse Practitioner: To	the best of r	my knowledge	e, death occurred	at the time,	date and pla	ace, and due to	the cause(s) a	and manner a	as stated.	
or w v o o		29b. Signature and	11/1	What I	N.D.	7	20	056	388		Febr	war	17th à	10/2
8	ı	30. Name and add	ress of person who	completed cause of	f death (Item	23a) (Type,	Print) Sin	ai t	toso	ital o	J R	alti	nove	
State		31. Date filed (Mon	oth, Day, Year) B 0 8 2012	completed cause of Shull 32. Regis	strar's Signa	iture La	W.				1			
Registra DHMH 17 Rev 06-20	-	1.5	D O CUIC	Commen	101	7				-				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2012 FEBRUARY 4:05 P M JOYNER DELMARE Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE 3600 W. FRANKLIN ST. APT 3D 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Hours 215-24-8088 Director 1 🗆 M 2 🗶 F Yrs APRIL 20,1926 85 Usual Residence of Decedent show 10d. Inside City Limits 10c. City, Town or Location must be notified at Director 28a-f 1X Yes 2 No BALTIMORE MD 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? ral", or items 23a Examiner must be Funeral USA 21229 3600 W. FRANKLIN ST. APT 3D death . Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 filed within 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 😾 No Specify. Specify: BLACK 'natural", 3 Widowed 4 Divorced Completed Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) id Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4 or 5+) the BEAUTICIAN COSMETOLOGY if Health and Mental Hygi item 27 is marked other other traumatic event, i Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မှ PEARL WILLIAMS ROBERT JOYNER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5118 PEMBROKE AVE. BALTIMORE, MD SHIRLEY SNELL/GADDAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date i of 1 🗶 Burial 2 🗆 Cremation 3 🗆 Removal from State Department of Important; If any injury or WOODLAWN CEMETERY 2-11-2012 BALTIMORE, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC. kames BALTIMORE, MD 1701-31 LAURENS ST. 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final VASCULAR PERIPHERIN Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examine Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) the burial-trar that initiated events Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 use as attending IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown for Month Day Year Pregnant at time of death ed by the a g Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ate has been signe page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, DIABETES 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy performed? Yes 2 N 1 🗌 Yes 2 🗌 No Yes certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital ၉ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work?
1 \(\sum \) Yes 28b. Time of 28d. Describe how injury occurred Certificate: Natural Acciden 5 Pending injury 2 No 24 hours after death, Funeral Director: A Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined Medical 1 Contifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitions: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hor To the Fune completely f only one) the 29b. Signature and title of certifie

State Registrar 31. Date filed (Month, Day, Year) 32. Registrar'

S (SU)
32. Registrar's Signature

EB 0 9 2012 Jeneur

CONNORS

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CYNTON

BACTIMORE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2012 Edward Joseph Kemp February 3:50 AMM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Rossville Baltimore Franklin Square Hospital Center 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Social Security Number Months Hours 0470977946 Maryland 65 Director 212 46 4637 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State must be notified at Director 1 Yes 2 No Maryland Baltimore Middle River 0 10e. Street and Number 10g. Citizen of What Country? 23a Funeral United States 21220 32 Nakota Court ral", or items ? permit. Page 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black White etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: white "natural", Completed 3 Widowed 4 Divorced Year or Dates the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nt of Health and Mental Hygiene.
If item 27 is marked other than or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Union/Construction Carpenter 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Beall Helen Virginia Everett Joseph Kemp 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
32 Nakota Court Middle River Maryland 21220 19a. Informant's Name/Relationship (Type, Print) (wife) Joan Kemp 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State matory or other place) Holly Hill Mem Gardens 2/8/2012 Baltimore Maryland Donation 5 Other (Specify) Bruzdzinski Funeral Home PA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 1407 Old Eastern Avenue Essex Maryland 21221 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest 23a. Part 1. Enter the disease shock, or heart failure. List only one cause on each line Onset and Death Immediate cause (Final Physician/ ARDIA disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine to (or as a consequence of): If any, leading to immedia cause. Enter Underlying Cause (Disease or iinjury the Hospital or Attending Physician: The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Vear 5 Other (specify) Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 X Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed' death? certificate 1 Yes 2 No Yes 2 No 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🔀 No Hospital: 2 1 Tes 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work?
1 Yes 2 No 1 X Natural 5 Pending injury 24 hours after death. Funeral Director: A Accident Investigation filled in by the 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier Excertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 ho

To the Fune

completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

(Check only one

29b. Signature and title of certifie

31. Date filed (Month, Day,

9 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

/ un

32. Regularar's Signature

W

29c. License number

2

3141

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Year ⊋o(⊋ 237 AM Dorothy Lee Kick Februar Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Ac. County of Death Examiner ALTIMOVE SAINT Agnes Hospi If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 😾 F Months Min (Month, Day, Year) Country) Maryland 218-30-5551 75 Director 24 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items on any injury or other trainment. 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No N/A Baltimore MD 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 21230 USA 1814 Morrell Park Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married à 1 Yes 2 YNO If Yes, Give Year or Dates. 1 ☐ Yes 2 TwNo Specify: Specify: White Completed 3 K Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Mary Sue Candy UKN Supervisor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Louis Smallwood Agnes Slaughter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shelly Gillespie-Granddaughter 549 Green Meadows Drive, Dallastown, PA 17313 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place)
Cedar Hill Cemetery Feb. 10, 2012 Brooklyn Park MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ambrose Funeral Home of Lansdowne 21. Signature of Funeral Service Licenses le 2719 Hammonds Ferry Road Lansdowne Maryland 2122 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ADATLE ANEUNESM ABDOMINAL disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death 9 Unknown signed by Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ nknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed 1 ☐ Yes 2 ☐ No certificate 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 IDOA eral Director: After this filled in by the funeral dii 28a. Date of injury (Month, Day, Year) 27. Manner of Dotth 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a Medical 🔀 ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 🗓 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) FEB 12UANY 6, 2012 50293 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

HOSPITAL.

AGNES

Registra's Sig

BACTIMONE MANTUMO

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 03596 For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ February 3, 2012 Hildur Henrickson Kull 11:55 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death National Lutheran Home Rockville Montgomery If Under 1 Year If Under 24 Hrs. Social Security Number **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Days 1 □ M 2 🗓 F NOV 28, 1921 Minnesota **Director** 477-16-8891 90 Usual Residence of Decedent show 10b. County at 10a. State 10c. City, Town or Location 10d. Inside City Limits Funeral Director must be notified 28a-f MD Montgomery Rockville 1 X Yes 2 ☐ No ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a 9701 Veirs Drive 20850 USA ral", or items 2 Examiner mus death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after 1 Yes 2X No Specify. "natural", 3 Widowed 4 Divorced Specify: White Year or Dates or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) d Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ M.A. Henrickson Hilma Peterson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 614 Fariston Drive Wynnewood, PA 19096 Department of Health a Important: If item 27 is any injury or other trains Stanley J. Kull/son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crematory 02/08/12 | Woodbine, MD 21. Signatur of Funeral Service Licer Going Home Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Ogset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑No 5 Other (specify) Day Month Year Pregnant at time of death 1 Yes 2 S sate has been signed by the a page 2 should be detached it Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director. After this certifical completed filled in by the funeral director, I 25. Was case referred to medica Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DQA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury Accident 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 0050612 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rockville mary land 2701 Veirs Drive MAIIENMD

DHMH 17 Rev 7/2009

State Registrar imature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 03597 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death February Physician/ 2012 Robert W. Krosney 9:30 A. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Anne Arundel 322 Seward Avenue If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** 1 🗙 M 2 🗆 F Months Hours (Month, Day, Year) 02/05/1943 69 Maryland 217 40 2578 **Director** Usual Residence of Deceden or 28a-f show notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County the Maryland by Funeral Director Anne Arundel Baltimore Maryland 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō must be Page 1 and 2 should be filed within 72 hours after death with 1 ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a 21225 U.S. 322 Seward Avenue Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11, Marital Status Hygiene. other than "natural", or iten ent, the Medical Examiner Black, White, etc. Yes 2 X No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: White 3 Widowed 4 X Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Economy Gasket Factory Worker 8th Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Walter Krosney Viola Mary Gralewski 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Baltimore, Maryland 21225 Edna Krosney 3705 - 2nd Street injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1
Department of Important: If it any injury or ol once. 1 X Burial 2 Cremation 3 Removal from State 02/11/2012 4 ☐ Donation 5 ☐ Other (Specify) Holy Cross Cemetery Baltimore, Maryland 22. Name and Address of Facility Gonce Funeral Service, P.A.
4001 Ritchie Highway Baltimore, Maryland 21225 21. Signature of Funeral Service Lice Rume 23a, Part 1, Enter the disease, (Complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line CARDIOVASENIAN Immediate Cause (Final AMENIOSCUENTIC Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Cause (Disease or iinjury that initiated events the Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live Birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Day signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by INCONTROLLED 1 Yes 2 No 3 Probably 4 Unknown MABETES 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗆 No certificate 1 TYes Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: Matural Natural 5 Pending 1 Yes 2 No ☐ Accident ☐ Suicide Investigation within 24 hours after death

To the Funeral Director: completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifier 29c. License number 21776

Registrar

2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ FEB. 2012 10:45AMM RUTH EDNA LAUMAN Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE STELLA MARIS HOSPICE TIMONIUM If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year Social Security Number 7. Age (In yrs. last birthday) **Funeral** Director 1 □ M 2**X** F MD. 220-09-2053 May 16,1919 92 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10b. County 10a. State 10c. City, Town or Location Director Timonium 1 Yes 2X X No Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21093 USA 2300 Dulaney Valley Rd. C 204 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Black, White, etc. þ 1XXNever Married 2 Married 1 Yes XX No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 🗶 No Specify. Specify: White 3 Widowed 4 Divorced Completed Year or Dates 2/02 16a. Decedent's Usual Occupation 15. Decedent's Education 16h Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Retail Sales Industry Sales Associate 12vrs. N/A Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Carl L. Lauman Elizabeth Clara Snyder 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4215 White Ave. Baltimore, Md. 21206 David L. Lauman (Nephew) 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Date Gardens of Faith XX Burial 2 Cremation 3 Removal from State 2-4-2012 Baltimore. Md. 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Lassahn Funeral Home 7401 Belair Rd. Baltimore, Md. 21236 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, Approximate Interval Between shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentiary list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami Cause (Disease or injury iding physician and use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical KuTI+ LAuMAN Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 r 1 Yes 2 9 Unknown months? Month Year Other (specify) Pregnant at time of death been signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 2 XNo 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has the funeral director, page 2 autopsy performe To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 1 🗌 Yes 2 X No ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: 5 Pending injury Natura Accident Natural Investigation 3 Suicide Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Fractitioner: To the best of my hoursely occurred at the time, date and place, and due to the cause(s) and manner as stated (Check 29b. Signature and 29c. License number death (Item 23a (Type, Print) 2300 32. Registrar's Signature 9 2012 State Registrar DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 03599 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day 201^{Yes} Mamie B. Lester Feb 6:00 A. M Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Harford County Examiner 4b. City, Town, or Location of Death Upper Chesapeake Medical Center Bel Air Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours 220-24-1197 Director 1 🗆 M 2 🔀 12/27/1925 86 West Virginia Usual Residence of Decedent 28a-f shov ms 23a or 28a-f sho must be notified at 0a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Cecil County Rising Sun Maryland 1 🗆 Yes 2 🄀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 270 Connelly Road 21911 United States items ; 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, the Medical Examiner Armed Forces?

1 Yes 2 XNo Black, White, etc. ò þ 1 Never Married 2 Married If Yes, Give Year or Dates Specify: White 1 ☐ Yes 2 X No Specify: "natural", Completed 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Clerical Retail Be 17. Father's Name (First, Middle, Last) 18. Mother's Name *(First, Middl*e, *Maiden Surn*ame) **Elizabeth Miller** and Mental I is marked o Department of Health and Menta Important: If item 27 is marked any injury or other traumatic evonce. ပ Ollie Sheets 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 270 Connelly Road, Rising Sun, Maryland 21911 George Lester (Son) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) 02/10/2012 Bel Air, Maryland Bel Air Mem Gdns 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Evans Funeral Chapel & Cremation Services-BelAir
3 Newport Drive, Forest Hill, Maryland 21050 Im Jam of 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Acute respiratory disease or condition Medical resulting in death) **Examiner** multiorgan Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examir Cause (Disease or injury that initiated events resulting in death) Last urosepsy and Due to (or as a consequence of) physician s the burial Physician/Medical ding IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Month Year Pregnant at time of death been signed by the a should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an funeral director, page 2 autopsy performed 1 Tyes 2 1 N Yes 2 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 1 No ျပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Accident
Suicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be

Division of Vital Records, P.O. Box 68760 M800389731 ESTER, MAINIE

To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has!

Medical 29a. Certifier Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

determined

D063420

February 7,2012

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Name and address of person who completed cause of death (Item 23a) (Type, Print) upper chesapeake or Bel Ar MD 21014.

4 Homicide

State Registrar 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 02^{Month} 06 8:42 PM 20°12 Physician/ Lowery Walter Clay Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Howard Ellicott City 4002 Dee Jay Drive Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number Age (In yrs. last birthday) **Funeral** (Month, Day, Year) Hours 213-22-1760 1**X** M 2 □ F **Director** 84 11/15/1927 Maryland Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a. State at rector 1 Yes 2 No Examiner must be notified Ellicott City Howard Co. MD ۵ 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ö 21042 23a Funeral United States 4002 Dee Jay Drive items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14, Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? Black White etc. ō 1 Never Married 2 X Married X Yes þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify. Year or Dates. WWII White "natural", 3 Widowed 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) 12 College (1-4 or 5+) Tractor Company Diesel Mechanic other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Kline ၉ Elsie Walter Lowery 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 4002 Dee Jay Drive Ellicott City, MD Mrs. Anna Marie Lowery /wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State Dulaney Valley Mem Prk. 2/10/2012 Timonium, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Singleton Funeral & Cremation |Services PA; 1 2nd Ave SW; Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or completations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physiciani 1D yeu monan disease or condition Medical resulting in death) Due / (or as a consequence of Examiner er nate Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examine signed by the attending physician and d be detached for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Caucen Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IE FEMALE: yes, outcome of pregnancy

Live Birth 2 D Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Month in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year 4 Pregnant a Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed plnous 24a, Was an 24b. Were autopsy findings available til prior to completion of cause of death? performed? 1 ☐ Yes 2 ☐ No certificate 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Certificate: To Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify Hospital: 2 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manger of Death 28c. Injury at injury ✓ Natural 5 Pending 1 Yes 2 No Investigation Accident filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

24 hours after death. Funeral Director: After this within 24 hore To the Fune completely f

5+11

State

Medical

4 Homicide

29a. Certifier

(Check

only one) 29b. Signature

determined

Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

Rive

Houll

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

The basis of examiners of the basis of examination and of invocascus, and the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or Investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

D2448

266, Elliet

29d. Date signed (Month, Day, Year)

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Adam Lenick, 0800 2012 February Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll 25 Westmoreland Street Westminster 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) **Funeral** Director 213-34-0291 1 X M 2 🗆 F 75 Jan 1, 1937 Pennsylvania Yrs. show 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location Examiner must be notified at Director 28a-f 1 XYes 2 □ No MD Carroll Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 0 items 23a Funeral 25 Westmoreland Street 21157 USA death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. ō 1 Never Married 2 Married þ 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White "natural", 3 Widowed 4 X Divorced the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry (Specify only highest grade completed) Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Printer Newspaper 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event Adam Lenick, Sr. Mary Zaraway 19a. Informant's Name/Relationship (Type, Print, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph Daniel Lenick/son 25 Westmoreland Street Westminster, MD 21157 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 🗆 Burial 2 💢 Cremation 3 🗀 Removal from State Final Journey Crematory 02/09/12 Woodbine, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service 22. Name and Address of Facility Coing Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 MO1251 23a. Part 1. Enter the disease, or complications that caus of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate

Cause (Disease or injury Examine Due to (or as a consequence of) as the burial-trar that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical certificate be Box 68760 IF FEMALE nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? for Month Day Year Pregnant at time of death signed by the at d be detached for 1 Yes 2 g Unknown 9 Unknown P.O. significant conditions confributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Part II. Other þ pe 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 has autopsy performed' death? 1 Yes 2 No this certificate 1 Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 1 ☐ Yes 2 ☐ No 2 4 Nursing Home 5 1 Inpatient 2 ER/Outpatient 3 DOA esidence 6 🗌 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Mann of Death 28b. Time of 28d. Describe how injury occurred Medical Certificate: 28c. Injury at s after death. work? iniury 5 Pending Natural 2 🗌 No ☐ Accident Investigation filled in by the 6 Could not be Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined within 24 hours a To the Funeral Completely filled Hospital Ecritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29d. Date signed (Month, Day, Year) 29b. Signature nd title of certifier State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND #2 Per DVR G924 2/10/2012 JH
State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 7 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2012 Physician/ February 2011 Esther Grigsby Martin 0900 A^{M} Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Silver Spring Holy Cross Hospital Montgomery If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral (Month, Day, NOV 14, Months Days Hours 1926 Director Washington DC 578-30-3160 1 □ M 2X F 85 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD Silver Spring Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20903 USA 10120 Avenel Gardens Lane 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🕅 No Specify: Specify Black Completed 3 Widowed 4 □ Divorced Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working (Specify only highest grade completed) life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Licensed Practical Nurse Healthcare Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Rachel Tolson James Henry Grigsby, Jr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10 North Pointe Terrace Middletown, MD 21769 Glen Martin/son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1
Burial 2
Cremation 3
Removal from State Final Journey Crematory 02/09/12 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licer Going Homes Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Uremia disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Acute Renal Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (cr as a consequence of) Chronic Kidney Disease Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last burial-tran and Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. been signed to should be det 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 X Unknown Completed Were autopsy findings available prior to completion of cause of death?
 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 2 No page 2 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 ☐ Yes 2X No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred injury 1 X Natural 5 Pending s after death. Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined 24 hours a Funeral D Medical 29a. Certifier 1🗶 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 24 hor To the Fune completely f Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 [only one) 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) D65305 02/06/12

Registrar
DHMH 17 Rev 06-2011

State

1500 Forest Glen Rd. Silver Spring, MD 20910

30. Name and address of person who completed cause of death (item 23a) (Type, Print)

32. Regis

Irina Ruban, M.D.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death February 6. Physician/ Kathleen Bridget Morrisroe 7:30 P.M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Stella Maris Nursing Home Timonium Baltimore Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 M 2 X F 552 30 3241 84 **Director** Califoria Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland **Baltimore** Baltimore 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4100 Maple Avenue U.S. 21227 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. þ 1 ☐ Yes 2 🛣 No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Religious Sister 4 years Religious Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Anthony Morrisroe Nellie Sullivan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sister Nora O'Flannigan 4130 Maple Avenue Baltimore, Maryland 21227 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 🗓 Burial 2 🗌 Cremation 3 🔲 Removal from State New Cathedral Cem. 02/10/2012 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 Part 1. Enter the disease, shock, or heart failure List complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any lace of the sequential sequential cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Dire to (or as a consequence of): attending physician and for use as the burial-transi Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 - Ectopic pregnancy 5 Other (specify) Month Day Year Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy death? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: မ 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death KATHLEEN Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 🗆 Yes Investigation Could not be Accident completed filled in by the 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 X Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) R 043580 02-07-2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2300 DULANEY VALLEY ROAD TIMONIUM, MD 21093 JUSTINE PREIS CRNP Registrar

DHMH 17 Rev 7/2009

Page Not Found

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.
AMEND ITEM#30perDVR,G924,2/9/2012,WS
State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 FEBRUARY 5:07 A M RUTH MARTIN AKA RUTH COHEN AKA RUTH PIKE Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** MONTGOMERY WASHINGTON ADVENTIST HOSPITAL TAKOMA PARK 7. Age (In yrs. last birthday) 1 Year If Under 24 Hrs 8. Date of Birth Birthplace (State or Foreign Country) Social Security Number **Funeral** Months Days Hours Min. (Month, Day, Year) 149-20-1407 **Director** 1 □ M 2 🗓 F 03/15/1928 NJ 83 Usual Residence of Deceder 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b County aţ Director notified 1 Yes 2 X No MD MONTGOMERY SILVER SPRING 10e Street and Number 10f. Zip Code ò 10g. Citizen of What Country? must be r Funeral 3152 GRACEFIELD ROAD 20904 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Examiner Armed Forces?

1 Yes 2 X No Black, White, etc. ō à 1 Never Married 2 Married Baltimore, Maryland 21215-0036 nours after 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify. "natural" Completed 3 Widowed 4 X Divorced WHITE Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the 5+ GRAPHIC ARTIST GRAPHIC ARTS Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental is marked ည PHILIP COHEN SALLY YABLICH traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trau once. STEVEN PIKE/SON 319 BENVENUE FARMS ROAD, LITTLE PLYMOUTH, VA 23091 20a. Method of Disposition 20h Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 XBurial 2 Cremation 3 X Removal from State MT. LEBANON CEMETERY 02/09/2012 ISELIN, NJ 4 Donation 5 Other (Specify) ture of Funeral Service Lice 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Trannetiz Intra evenil Joh Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Heint diseste Examiner mentensive Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examin Fibrile 104 and that initiated events Due to (or as a consequence of): resulting in death) Last burialrebrouggenlan Accolent physician Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 the as IF FEMALE: use 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 9 Unknown 9 Unknown signed by n Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy page death? Hospital or Attending Physician: The 2 🗌 No 1 Tes Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 No 1 Yes ၉ 1 Npatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work?
1 Yes 2 No 1 Natural iniury 5 Pending ie Funeral Director: Affoletely filled in by the fu Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Siar 29d. Date signed (Month. Dav. Year) 02/07/2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Emergency Medicine Associates @0010 Century Blvd. Germantown, MD James Lightfoot Jr. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

ORIGINAL

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Minter Vanguard 10 40A 2012 Medical 4a. Eacility Name (if not institution, give street and number) Gity, Town, or Location of Death **Examiner** County of Death Kandallstown timore If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday 8. Date of Birth **Funeral** Days (Month, Day, Year) 217-78-917 Director 1 M 2 D F 5-1960 MD 51 ral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location with the Maryland 10d, Inside City Limits Director 1 Yes 2 No 10e. Street and Number 10g. Citizen of What Country? Funeral permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu once. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban-Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married Yes Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working life DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, မ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 'l e 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Lecation - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State demetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Funeral Services MD31133 au 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Pnysician/ Colon Cancer disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) the Hospital or Attending Physician; The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) resulting in death) Last To Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 as attending ; IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery ed by the atten-3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year Pregnant at time of death 1 Yes 2 L 9 Unknown 9 Unknown this certificate has been signed by rail director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an yes 2 No 1 Yes within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other Specify nosp, ce 1 Tyes 2 1 No Other: 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28c. Injury at work? 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 Tyes 2 🗌 No Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MSRajapahlM.D 00057465 2/6/12

Registrar DHMH 17 Rev 06-2011 Bultimore MD 21709

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
N · S · Rayapa KHL / MID · 2835 S m IPM AV \$ 203

32. Registrar's Signature

N.S. Rajapakte, M.D

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month eBEVAP Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death BALTIMO OW SON 8. Date of Birth (Month, Day, Aug • 2, 9. Birthplace (State or Foreign Country) Maryland Social Security Number 6. Sex 1 X M 2 □ F 7. Age (In vrs. last birthdav) If Under 1 Year If Under 24 Hrs. Funeral Hours 89 Director 215-14-5143 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location ral", or items 23a or 28a-f sho Examiner must be notified at 10d. Inside City Limits death with the Maryland Director 1 🗆 Yes 2 🔀 No MD Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 800A Southerly Road #639 21286 USA 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Bace - American Indian Armed Forces?
1 X Yes 2 □ No Yes, specify Cuban, Mexican, Puerto Rican, etc. Black White etc. 1 Never Married 2 X Married Completed by 3 Baltimore, Maryland 21215-0036 filed within 72 hours after permit. Page 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, the Medical Examore. 1 ☐ Yes 2 X No Specify: If Yes Give 3 Widowed 4 Divorced Specify: white Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Director Missle Program U.S. Navv Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Hamlin Ben Mallonee Irma Evelyn Whelpley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) wife Amelia K. Mallonee 800A Southerly Road #639; Towson, MD 21286 20b. Place of Disposition (Name of 20c. Location - City or Town, State 4 ☐ Donation / ☐ Other (Specify) 2/7/2012 Hilltop Service Corp. Towson, MD 21. Signature of P Feral S 1050 York Road 22. Name and Address of Facility Towson, MD 21204 Ruck Towson Funeral Home, Inc. 23a. Part 1. Enter the disease, or compli-shock, or heart failure. List only on nons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest ause on each line. Approximate Interval Between
Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of): physician a the burial-Physician/Medical Box 68760 the attending phoped IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Month Day Year signed by the a 9 Unknown Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an **Director:** After this certificate has a in by the funeral director, page 2. autopsy performe 2 No 1 Yes Yes 2 No 25. Was c → e referred to medical examiner?
1 ✓ Yes 2 ☐ No Be 26. Place of Death (Check only one) Hospital: Other: ျပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 Natural
2 Accident
3 Suicide
4 Homicide 5 \square Pending 1 🗌 Yes 2 🗌 No Investigation filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined hours after within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 31. Date filed (Month, Day, Year 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #19a Per FH G924 2/09/2012 JH State of Maryland Department of Health and Mental Hygiene For State Registrar 03608 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 02 2012 7:06 PMM Ida Julia Neiser Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Gilchrist Hospice Towson, Maryalnd Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth 9. Birthplace (State or Foreign Country) Maryland **Funeral** Social Security Number 6. Sex Age (In yrs. last birthday) (Month, Day, Year) 05/27/1933 1 □ M 2 🔀 F Min **Director** Yrs <u>212-32-1885</u> 78 Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f shov ury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Harford 1 Yes 2 X No Joppa 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21085 241 Haverhill Road U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes, Give Year or Dates Specify: White 3 X Widowed 4 Divorced 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 8 Self = Employed Care Giver Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Mary Tremper John Kahl 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sandra Sandrea Neiser (daughter) Haverhill Road - Joppa, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 💢 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) permit. Page
Department o
Important: If
any injury or
once. Air Memorial Gdns.02/10/2012 Bel Air, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. A) 6 11750 Belair Road - Kingsville, Maryland 21087 assaks 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ monary disease or condition resulting in death) weenic 120C Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence or Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IE FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day 5 Other (specify) Pregnant at time of death ed by the a detached f 9 Unknown 9 Unknown within 24 hours after death.

To the Funeral Director; After this certificate has been signed by is completed filled in by the funeral director, page 2 should be detact. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by CANCU 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy Yes 2 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 2 **2**No မ OUG 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 28c. Injury at 1 Naturai injury 5 Pending 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier

DHMH 17 Rev 7/2009

State

Registrar

ack

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HALLES

32. Registrar's Signature

AANON 31. Date filed (Month, Day, Year)

FEB 0 9 2012

29d. Date signed (Month. Day, Year)

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician/ ZOAM 6 2012 Delores Sadie Neil Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death Examiner Ballimore FRANKLin Square Hospital Rosedal If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Hours Min. (Month, Day, Year) **Director** 215-32-1790 1 🗆 M 2 💢 F 79 8/23/1932 Maryland Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10a. State 10b. County 10c. City. Town or Location ä **Funeral Director** notified 28a-f 1 Yes 2 X No Maryland Baltimore Middle River 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be n 0 10200 Bird River Road 21220 S. Α. items 2 12 Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. 11. Marital Status r than "natural", or ite the Medical Examiner Armed Forces?

1 Yes 2 X No Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify: Completed 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Baltimore County Public School System alth and Mental Hygiene. 27 is marked other than r traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Dining Room Aid Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Page 1 and 2 should be John Goles, Sr. Lillian Eugenia Reid 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other traionce. Helen Eugenia Hayden (Daughter) 1419 My Ladys Drive Abingdon, Maryland 21009 20a. Method of Disposition 20b. Place of Disposition (Name of 2/9 2012 20c. Location - City or Town, State cemetery, crematory or other place) 1 XBurial 2 Cremation 3 Removal from State Holly Hill Mem. Gard. 4 ☐ Donation 5 ☐ Other (Specify) Middle River, Maryland 22. Name and Address of Facility Bruzdzinski Funeral Home 1407 Old Eastern Avenue 21. Signature of Funeral Service Licenses Maryland 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ patic Encephalopathy disease or condition Medical resulting in death) (or as a consequence of): Examiner Stace disea Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of). burial-transit Cause (Disease or injury that initiated events resulting in death) Last CIFTHOSIS and Due to (or as a consequence of): physician Hepatitis To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the use as attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) Pregnant at time of death signed by the ar Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an cate has page 2 s autopsy performed death?
1 Yes 2 No certificate Yes 2 No 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be Other: 1 ☐ Yes 2 ☑ No 0 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death. To the Funeral Director: After this 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred iniury 1 Natural 5 Pending Investigation work? 1 ☐ Yes 2 ☐ No Accident filled in by the 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) oratala, dama

3 Mg

Registrar

DHMH 17 Rev 06-2011

FRANKLIN SQUARE DR Balto Md 21237

9000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

tota

Dora

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death February Physician/ 2012 ear 1:55 A Sharon L. Neese Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Towson Gilchrist If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Year) Months Days Hours Min. 217-48-9098 Director 1 □ M 2 💢 F Feb. 16, 61 1950 |South Carolina Usual Residence of Decedent 28a-f show 10d. Inside City Limits with the Maryland 10a. State 10b. County 10c. City. Town or Location Director notified 1 Yes 2 No MD Baltimore Baltimore 10e. Street and Numbe 10f. Zip Code 10a. Citizen of What Country? ò ms 23a or Funeral USA 21234 8 Peroba Court permit. Page 1 and 2 should be filed within 72 hours after death \times Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner muones. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2 X No þ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Completed 3 Divorced white Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) 4 Materials Planner Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Ethel Lee Jones Bynum M. Neese 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1020 Tan Tara Circle; Lake Charles, LA 70611 Susan L. McHugh sister 20a. Method of Disposition
1 ☐ Burial 2 ☒ CA mation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Date Other (Specify) 2/8/2012 4 Donation 5 1 Hilltop Service Corp <u>Towson, MD</u> 21. Signature of Funeral Socice Lig 22. Name and Address of Facility 1050 York Road MD 21204 Ruck Towson Funeral Home. Towson. that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or complicat shock, or heart failure. List only one c Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ mets som c Colon Cance disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Litter Underlying Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): ending physician are use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Other (specify) Pregnant at time of death 4 Pregnant : 9 Unknown been signed by the sahould be detached 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 No 3 Probably 4 Unknown Be Completed Were autopsy findings available prior to completion of cause of 24a. Was an cate has autopsy performe death? 1 Yes 2 No 1 Yes 2 N 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence Hospital: Other (Specify) WOS) UCP 2 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred After 1 Natural injury 5 Pending 124 hours after death Funeral Director: A letely filled in by the f Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 ho

To the Fune

completely f Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) LOIL 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JUN NOSCOLL UES M

Registrar DHMH 17 Rev 06-2011 32. Registrar's Signature

N

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 2 1 - For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ February 2012 4:00P Rotha Peterson Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Baltimore Gilchrist Hospice Towson Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Days 1 X M 2 A F Months Hours Min March 22 1932 Greensville, NC 79 243 48 1867 **Director** Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location with the Maryland notified at Director Maryland Baltimore City Baltimore City 1X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be r Completed by Funeral 21206 USA 6607 Walther Avenue Apt TA permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu once. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ X No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify. White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Gardens of Faith Cemetery Caretaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ Tice Peterson Zora Christine Deaton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 422 Woodcrest Drive Aberdeen, Md. 21001 Michael T. Peterson (Son) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place, Metro Creamtory Inc February 6 2012 Baltimore, Maryland Lassann Funeral Home Inc 7401 Belair Rd Baltimore, Maryland 21236 ign turn of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last and the burial-tran Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown signed by the atte Month Pregnant 5 Other (specify) Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed plnods 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? 1 Yes 2 No Yes 2 L director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner2 1 ✓ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Nother (Specify ပ 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending injury s after de. ral Director: A Accident Investigation 6 🗌 Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours after Funeral Dire leted filled in b Medical Exertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hor To the Fune completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) of certi 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title 040 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SUITE GIOS 32. Registrar's Signature State FEB 0 9 2012 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ February 5, 2012 2:00 A M Catherine Popp Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 2 Summit Hill Ct. Apt A Catonsville Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex . Age (In yrs. last birthday **Funeral** 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 1 🗆 M 2 🔀 Months Hours Country) Maryland 214-16-5733 89 Director 26 1922 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits and 2 should be filed within 72 hours after death with the Maryland Director 1 🗌 Yes 2 🗓 No Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21228 USA 2 Summit Hill Ct. Apt A 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian. the Medical Examiner Black, White, etc. ö þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 🗆 Yes .2 🔀 No "natural" Completed Specify: White 3XXWidowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Housewife Own Home traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 9 Samuel Lusco Josephine M. Serio 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 2832 Michigan Avenue, Halethorpe Maryland 21227 Christine Packer-Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Page 1 a Department of I Important: If its any injury or of ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Feb.8,2012 Glen Burnie Maryland tlantic Crematory 21. Signature of Fuperal Service Lice 22. Name and Address of Facility Ambrose Funeral Home Inc. Um 1328 Sulphur Spring Road Arbutus Maryland 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ ronic Medical Due to (or as a consequence of) Examiner Sequentially list conditions Due to (or as a consequence ut) ff any leading to in media cause. Enter Underlying Cause (Disease or linjury the attending physician and ched for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis Box 68760 IF FEMALE yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death Pregnant at time of death 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Year detached 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by page 2 should be 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No 1 Yes 2 No in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 \(\text{Yes} 2 No မှ 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 \square Pending work?
1 \(\sum \) Yes 2 \(\sum \) No ☐ Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Output in the cause(s) and manner at the cause(s) and manner stated. 29a. Certifier соmpleted (Check 29b. Signature and litle of certifier 29c, License number 29d. Date signed (Month, Day, Year) 00059914 who completed cause of death (Item 23a) (Type, Print) 15V North Folling Road Baltimore, Haryland

DHMH 17 Rev 7/2009

State Registrar

			Fleas	Ctete of Manualen			-	_	
			For State	State of Marylan	d / Department of H Certificate of L			71117	03613
			Registrar 1. Decedent's Name (First, Middle, L	ast)	Certificate of L		Reg. I	No	3. Time of Death
	Physic		Anna Delore	1/	Parham			Day Year	11:15 AM
-	Med Exam		4a. Facility Name (if not institution, gi			Location of Death	- 1	4c. County of Death	1777.0
			Franklin 594	are Hospita	1 20520	lale		Baltim	970
- 1	Funera	_	5. Social Security Number 6.	Sex 7. Age (In vrs. la	Months Days	If Under 24 Hrs. 8 Hours Min.	. Date of Birth (Month, Day, Yea)	9. Birth	place (State or Foreign
	Directo	r	212-40-0250 Usual Residence of Decedent	(4)	Yrs.		(Month, Day, Year	942	190
	and show I at	5	10a. State 10b. County	10c. City	, Town or Location	-		1	10d. Inside City Limits
	Maryla 8a-f	le ct	MD N/	A Ba	Himore				1 Yes 2 No
	with the Maryland ; 23a or 28a-f sho ust be notified at		10e. Street and Number		10f. Zip Code		10g.	Citizen of What Cour	ntry?
	h with ns 23 must	Funeral Director	1000 Frankli	n Ave. Apt.+	F1007 210			USA	
	r death r items iner mu		11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in U.S Armed Forces?	13. Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Specif in, Mexican, Puerto Ric	y Yes or No- an, etc.)	14. Race - Americ Black, White,	
ರಜ	s after al", o	d b	3 Widowed 4 ☐ Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates.	1 ☐ Yes 2 X No	Specify:		Specify: Blace	2K
A NNG	within 72 hours after giene. er than "natural", or, the Medical Exami	Completed by	15. Decedent's (Specify only highest	Education	16a. Decedent's Usual Occup	ation	16b	. Kind of Business In-	dustry
A	nin 72 ne. han "	l E	Elementary/Seconday (0-12)	College (1-4 or 5+)	(Give kind of work done of life. DO NOT use retired)		13	1.0 1/2	. K.L
	d with dygier ther t	BeC	12 Feeth avia Name (First Middle Lea	N/A	Cashier			uper Mai	- ICCT
5	should be filed within and Mental Hygiene. is marked other tha raumatic event, the In	To B	17. Father's Name (First, Middle, Las Addison Van CE	•		18. Mother's Name (F	Marine		
S I	ould but Me mark		Hadissh Yan CE 19a. Informant's Name/Relationship		19b. Mailing Address (Street	and Number or Bural B			Code)
Parham Manyan	d 2 sh alth al 1 27 is or trau		Pamela Sherin	an - Daughter	4006 Century	Rd. Bak	timore,	UD 212	06
8	of He rother other		20a. Method of Disposition		lace of Disposition (Name of Cemetery, crematory or other place	Dat	e 20c.	Location - City or To	own, State
· <u>È</u>	Page ment o ant: If ury or		1 Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe	I removariioni ctate	rrison Fores	1 11016		VingsMil	
farham	permit. Page 1 and 2 should be fload within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at	5	21. Signature of Funeral Service Lice		22. Name and Addres	11.15	ch FIH Eas	+ Ild E. Nor	the the.
		0	23a. Part 1. Enter the disease, or co		1 13altimore	110	conjectory errect		Annundanata
			shock, or heart failure. List only Immediate Cause (Final	one cause on each line.	n. Do not enter the mode of dyin		1		Approximate Interval Between Onset and Death
- 4	Physician Medica		disease or condition resulting in death)	a. Cardio (e Due to (or as a consequ	spicatory	HILLES	<i>†</i>		
	Examine			51 to a sille	Matastati	4 Adams	Carrie	- ama	
		ner	if any, leading to immediate cause. Enter Underlying	Due to (or as a consequ	The State of the S	Havne		1011111	
	cuted nd ransit	Examiner	that initiated events	· Coronary		isease			
	be executed sician and burial-transit	calE	resulting in death) Last	Due to (or as a consequ	,	0			
760	ate b	edic		d. Hemipar	25;5 5/P	CVA			
6876	eath certificate t attending phys	N N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnal	ncy			23d. Date of deliv	verv
S	eath c	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live Birth 2 Feta 4 Pregnant at time of d		су		Month	Day Year
	requires that the de been signed by the s	Physician/Medi	9 🗌 Unknown	g Unknown					
٥	s that gned be de	ğ	Part II. Other significant conditions	s contributing to death but not res	ulting in the underlying cause gi	ven in Part I.		o use contribute to the	he cause of death?
70	equire een s nould	eted							
Division of Vital Records	or Attending Physician: The law requires that the death certificate After death. Director: After this certificate has been signed by the attending phy in by the funeral director, page 2 should be detached for use as the	Completed					24a. Was an autopsy performed	prior to co	opsy findings available ompletion of cause of
B	n: The ficate or, pag		25. Was case referred to medical		ac Di	ace of Death (Check o	1 Yes 2 N		2 No
/ita	sicial s certi	To Be	examiner?	Hospital:	ER/Outpatient 3 DOA Oth	er.		6 Other (Specify	w)
-	ding Physician: The la h. Affer this certificate ha funeral director, page		27. Manner of Death	28a. Date of injury (Month, Day, Year)	28b. Time of 28c. Injur	y at 28	d. Describe how in		7
5	endin sath. or: Aft	ficat	1 Natural 5 Pending 2 Accident Investigat	ion		Yes 2 No			
: <u>0</u>	or Attendi after death. Director: A lin by the fu	Certificate:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determine		me, farm, street, factory, office	28	f. Location (Street City or Town, Sta	and Number or Rura ate)	l Route Number,
Ë	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completed filled in by the fu	Sal	29a, Certifier 1 Certifying P	hysician: To the best of my knowl	adda dooth aggived at the time	dete and sleep and a	due to the course(s)	and manner as state	ad.
1	24 hc Fun	Medical	(Check 2 Medical Exa	iminer: On the basis of examination urse Practioner: To the best of my	and/or investigation, in my opinion	on, death occurred at th	e time, date and pla	ace, and due to the ca	ause(s) and manner stated.
(2)	Vithin To the Comp	2	29b. Signature and title of certifier	2	29c. Licens			Date signed (Month,	
			* Khoha	~ MD	Res	0000		2-1-6	3019
0			30. Name and address of person wh		23a) (Type, Print)				
~			Oc Fathrya		Franklins	square D	rive Ba	1timore	MD 2125,
	Si Regis	tate trar	FEB 0 9 2012 Z	32. Registrar's Signat	ales				
X D	HMH 17 Rev 7								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Ann Marie Peterson 2012 February 6:06 P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 403 Whitcliff Court Montgomery Gaithersburg Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth **Funeral** 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Sept 1, 1927 Pennsylvania Director 129-22-7757 1 M 2 X F 84 Usual Residence of Decedent show at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director notified 28a-f MD 1 X Yes 2 No Montgomery Gaithersburg the ! 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be Funeral 23a 403 Whitcliff Court 20878 USA items death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. nan "natural", or iter Medical Examiner Black, White, etc. 1 Never Married 2 Married Ď Yes 2X No Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after 1 Yes 2X No Specify: If Yes, Give Year or Dates Specify: White 3 X Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) d Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4 or 5+) the Homemaker Own Home 12 event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) and Mental F 2 Albert Toth Anna Uhrin other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Christine Peterson/daughter 403 Whitcliff Court Gaithersburg, MD 20878 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crematory 02/06/12 Woodbine, MD permit. 21. Signature of Funeral Set Cong. Name and Address of Facility Sing. Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one one se on each line. Interval Between Immediate Cause (Final Onset and Death Ph_sician ementa disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Exami use as the burial-trar Due to (or as a consequence of) ding physician Physician/Medical The law requires that the death certificate be P.O. Box 68760 yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ atten in the past 12 months?

1 Yes 2 No Pregnant at time of death Month Day Year signed by the at d be detached for Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed yperlipidemia 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed Yes 2 page 2 has After this certificate 1 ☐ Yes 2 ☐ No B Hospital or Attending Physician: 24 hours after death.
Funeral Director: After this certifications 25. Was case referred to medical Division of Vital funeral director, 26. Place of Death (Check only one) Be examiner? Hospital Other: 4 \(\triangle \) Nursing Home 5 \(\triangle \) Residence 6 \(\triangle \) Other (Specify) 은 2 No 1 Inpatient 2 I ER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred injury 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation completely filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Xertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) b34386 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 70850

M DHMH 17 Rev 06-2011

State Registrar onnor

13

9715 MEdical Ctr Dr.

2-01035	Please Type or Pr	rint in Black Indelible Ink. Ensure	All Copies Are Legible.		
amara Sue Miller Poretski	State of M	Maryland / Department of Health and	Mental Hygiene	201	2 036
1- For State Registrar		Certificate of Death	Reg. No.	i 0 1 1	
	's Name (First, Middle,Last)	Tamara Sue Miller Poretsky	2. Date of Death Month Day February 4, 2012		3. Time of Death 0238 hrs

	Registrar						Cen	iticate (OT I	Deair	1				Reg. No			
Physician/ Medical Examiner	1. Deced	lent's Name	(First, Midd Tamara	_	Tama	ra Su crets	e. M	iller						. Date of De Month February	Day 4, 20			3. Time of Death 0238 hrs
					street and no n Mill Roa					o. City, To Spark		ocation of	Death			c. County of D Baltimore		nty
Funeral	5. Social	Security No	umber	6. Sex		7. Age (Ir	n yrs. las	st birthday)	1	If Unde		If Under		8. Date of E	Birth (MM			place (State or
Director	085-	·48 - 57	07	1 N	1 2 X F		48	١	rs.	Months	Days	Hours	Min.	Nov.	11,	1963	oreign Cou	ntiNew York
, any	Usual Re	esidence of	Decedent 0b. County			1100	c. Citv. T	own or Loc	atio	n							$\overline{}$	10d. Inside City Limits
8	MD.		Balti	nore			Spar											1 Yes 2 X No
uylane tar sh		et and Num		nor c	-		- 1		Т	10f. Zip	Code				10g. Cit	tizen of What	Count	try?
with the Maryland ns 23a or 28a-f sho be notified at ouce.	1	25 Eng	glish	Run	Circl	e			-	21	.152					U	SA	
more, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland reat of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f also or other transmatic event, the Medical Examiner must be notified at sonce TO Be Completed by Furneral Director		al Status			12. Was De		er in U.S							cify Yes or Nican, etc.)	10-	14. Race - A White, 6		an Indian, Black,
r death with or items 23 must be no			d 2 ∐ M		1 Yes	2 X	No							, , , , , , , , , , , , , , , , , , , ,				
rs after rral", miner	3 W				Yes, Give Ye or Dates: highest gra		ted)	16a, Decec			X No		ind of wo	rk done	16b.	Specify: W		
2 hour "nath	Eleme		ndary (0-12)		100 000 000	1-4 or 5+)						DO NOT						·
17215-0036 Id be filed within 72 hours af Aental Hygiene. arriced other than "natural event, the Medical Examin					5	+		Para	1e	gal					I	aw		
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than ic event, the Medical To Be Comple			First, Middle											First, Middle		n Surname)		
2121 hould be fill and Mental Is is marked tric event,		Willi	Lam T		Miller			40h Mai	lima	A ddrana	/C)===1	Suza	nne	Scor	se	City or Town,	State	Zin Coda)
MD 21215-003 d 2 should be filed with the and Mental Hygience in 27 is marked other it animatic event, the Mes To Be Com	4				Mother			1.			a St					L. 3 <u>39</u>		Zip Godey
ore, MD 2 s: 1 and 2 shoul of Health and N If item 27 is n her traumatic	20a. Met	thod of Disp	osition					ace of Disp	osit	ion (Nam				Date	20c.	. Location - C	ity or T	Γown, State
norgages 1 and of 1 tr. If it.		_			Removal f	rom State		ematory or 1top			ce Co	,	2-8-	12	ΙI	Cowson,	MI	o .
Baltimore, MI permit. Pages 1 and 2 s Department of Health a Important: If item 27 injury or other traum	21. Sign.	ature of Fun	Other S	cense	1		1122									, Inc.		
in In De Co		10	10	M	<u>/</u>					1()	n() Yo	ork K	d. I	owson	. ML). ZIZU	14	
Physician (Wedical)	23a. Par failu	t∦: Enter the ure. List only	disease, or y one cause	complic on each	cations that on the contract of the contract o	caused the	death.	Do not ente	er the	e mode o	of dying, s	uch as ca	irdiac or i	espiratory a	irrest, sr	nock, or heart		Approximate Interval Between Onset and Death
Examiner		ite Cause (F	Final disease g in death)		lultiple in ue to (or as		ence of)		_	_	_						\dashv	Beau.
,	Sequent	tially list con	iditions,	b													_	
ted Insit	if any, le cause.		rlying Cause		ue to (or as	a consequ	ence of)	:										
xam it	events r	e or injury the esulting in o		Di	ue to (or as	a consequ	ence of)				-							
760, ficate be executed physician and the burial - transit				d	****													
8760, ificate be execu g physician and s the burial - tra		NPENDED		X		#lper		G924,	2/	9/20	12,W	S			12	3d. Date of de	elivery	
8760, tificate being physic as the burnar in/Med	IF FEMA		oregnant in t	he	23c. If yes,		or pregn	-	Feta	al death	3	Ectopic	pregnan	су	12	Month	•	ay Year
ox 6 ath cer attendi	1 1 Y		ilo 9 🗸 Un	known	4 Preg	nant at tim	e of dea	th 5		er (Spec	cify)				- 1			
by the attendin to be the attendin to be the attendin to be defered for use a Physicial	Part II. C	_			ontributing		ut not re	sulting in th	e ur	nderlying	cause giv	ven in Par	rt I.	23e. Dic	tobacco	o use contribu	ite to t	he cause of death?
P.C es that igned I be deta	1													1 🗆 Y	'es 2	✓ No 3	Prob	ably 4 Unknown
rds, requir requir been s bould letec														24a. Wa	as an opsy			opsy findings available ompletion of cause of
Records, The law requires ficate has been sig														per	formed?	? dea	ath?	
cian: Ti certifica	25. Was		ed to medica									of Death (
F Vita	1		2 No	Но	ospital: 1	Inpatient		ER/Outpati								dence 6 🗸		Scene
ding P. After funers	27. Man	ner of Death Natural		ding	28a. Date (Mont Feb 4,	e of Injury h, Day,Year) 2012	,	28b. Time 0230 hrs	of In	ijury 12	_	≀at Work? es 2 ✔	In			njury occurred to fixed o		t collision
Sior Attend r death ector: by the	2 🗸	Accident	Inve	estigation	28e Pla			me, farm, s	treet	t. factory				28f. Location	(Street	and Number	or Rur	ral Route Number, City
Division o spital or Attending hours after death. neral Director: After filled in by the function:	3	Suicide Homicide		ıld not be ermined	e			l / Highw		.,	,	o,						oad, Sparks, MD
		rtifier 1	Certifying F	hysicia	n: To the be	est of my kr	nowledg	e, death oc	curr	ed at the	time, dat	e and pla	ce, and c	lue to the ca	use(s) a	and manner a	s state	ed.
To the Ho within 24 To the Fu complete!	one)	2 🖳		8	On the basis and manner		ation an	d/or invest	igatio				curred at	the time, da		lace, and due		
	29b. Sig	nature and	title of certifi	er /	A					290	c. License O.C.N					l. Date signed bruary 4, 3		nth, Day, Year)
	Yavi	west v	rothell	, My	0		4ls /14:	020)			U. U. IV	''. .						
0			ess of perso Southall, I		ompleted car Assistant				900	W. Ba	altimore	Street,	Baltim	ore, MD	21223	3		
State			h, Day,Year			Registrar's												
Registra		ER O O	2012	h	-401 4	-	don	the						00145				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registral Certificate of Death . Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ February 7, 2012 5:55 \mathbf{P}_{M} Robert James Pugh Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Baltimore Essex 309 Essex Avenue 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number **Funeral** Days 1 ☑ M 2 □ F 0271271938 Maryland 212-38-1781 73 **Director** Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland at **Funeral Director** notified 1 Yes 2 No Maryland Baltimore **Essex** 10a. Citizen of What Country? 10e. Street and Number 10f. Zip Code ö items 23a or ner must be n U.S.A. 21221 309 Essex Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status 12. Was Decedent Ever in U.S. ian "natural", or ite Medical Examiner Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married 1956 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Yes. Give Specify: White Completed 3 Widowed 4 M Divorced 1959 Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) ed other than " event, the Med Lever Bros. Mfg. Elementary/Seconday (0-12) 12 College (1-4 or 5+) Machine Operator Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental Fis marked of ပ Louise Rouiller Leroy Pugh 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health art: If item 27 is 540 "C" Carrollwood Road, Baltimore, Maryland 21220 Michael Pugh (Son) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or oth once. cemetery, crematory or other place 1 🔀 Burial 2 🗌 Cremation 3 🗌 Removal from State Baltimore, Maryland Holly Hill Mem. Gard, 02/11/2012 4 Donation 5 Other (Specify) ^{22. Name and Address of Facility}
Bruzdzinski Funeral Home, P.A.
1407 old Eastern Avenue, Essex, Maryland 21221 of Fu, eral Servi e License complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Enter the disease ck, or heart failure. Lis Immediate Cause (Final Meta Smallcel Proyumiano Medical disease or condition resulting in death) **Examiner** Sequentially list conditions, Examiner Due to (or as a consequence of, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury physician and s the bunal-trans that initiated events Due to (or as a consequence of) resulting in death) Last Completed by Physician/Medical nding p use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No Month for Day Year Pregnant at time of death been signed by the should be detached 1 ☐ Yes 2 L 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performed? Yes 2 No 1 🗆 Yes 2 🗆 No certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) director. Be Hospital Other: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Tes 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) ၉ 28c. Injury at work?
1 Yes Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural iniury 5 Pending 2 🗆 No Investigation Accident

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 After within 24 hours after death

To the Funeral Director,
completed filled in by the f

. On

6 Could not be

determined

Suicide

4 Homicide

Medical 🕻 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Gertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

who completed cause of death (Item 23a) (Type, Print) Marshalle Dr. Flkridse . Date filed (Month, Day, Year, 32. Registrar's S

State Registrar 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death February D Day 3 Zoiz 5:00 P M Physician/ tatterson Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Co. Windsor Mill Northwest Hospice If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) 5. Social Security Number 216-54-0306 **Funeral** Hours 1 □ M 2 🖵 F Director 05/15/1941 Maryland 70 28a-f show 10c. City, Town or Location aţ 10a. State 10b. County Director ms 23a or 28a-f s must be notified N/A Baltimore 1 XYes 2 No MD 10f. Zip Code 10e Street and Number 10g. Citizen of What Country? Funeral U.S.A. 21215 3629 Wabash Ave. permit, Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian. Examiner If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ō 1 Never Married 2 Married Completed by Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: Specify: Black 3 ₩ Widowed 4 □ Divorced "natural" the Medical 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) life. DO NOT use retired if Health and Mental Hygiene.
item 27 is marked other than other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Self Homemaker 9th Grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 9 Marie Braxton unk 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3629 Wabash Ave., Baltimore, MD 21215 Glenda Vann(daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of Important: If it any injury or o cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 02/10/12 Baltimore, MD Arbutus Cem. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signat of Funeral Service Licensee Joseph H. Brown Funeral Home PA 2140 N. Fulton Ave., Baltimore, 00 MD21217 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Multiple Myeloma disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Elect of conjung Cause (Disease or injury Due to (or as a consequence of) ig physician and as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Records, P.O. Box 68760 the attending IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? detached for Month Day Year Pregnant at time of death 1 ☐ Yes ∠ ☐ 9 ☐ Unknown g Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Disease Kena 1 Yes 2 No 3 Probably 4 Inknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy certificate has performed 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No Division of Vital funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA မ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Injury at 28d. Describe how injury occurred Certificate: injury work 1 Natural 5 Pending 1 🗌 Yes 2 🗌 No 24 hours after death. Funeral Director: Af Investigation Accident the 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie within 24 hor

To the Fune (Check

State Registrar

2835 the Grenue Smi 31. Date filed (Month, Day, Year) FEB 0 9 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

only one

29b. Signature and title, of certifie

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

DOUS 3337

1203

29d. Date signed (Month, Day, Year)

February

Baltimore

4 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Joseph John Riley 07, 10:03 P M 2012 Feb. Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 107 Mainsail Drive Stevensville Queen Anne If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) **Funeral** 88 Director 353-07-8512 1**X** M 2 □ F Feb. 14, 1923 Illinois Usual Residence of Decede or items 23a or 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits other traumatic event, the Medical Examiner must be notified at Director MD 1 Yes 2X No Oueen Anne Stevensville 10f, Zip Code 10g, Citizen of What Country? Funeral 107 Mainsail Drive 21666 USA filed within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Race - American Indian. Armed Forces? 1X Yes 2 ☐ No Black, White, etc. þ 1 Never Married 2XXMarried Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give "natural", Specify: White Completed 3 🗆 Widowed 4 🗆 Divorced Year or Dates. 1943-46 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Il Hygiene. College (1-4 or 5+) **2+** Elementary/Secondary (0-12) Sales Executive Appliance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fis marked o permit. Page 1 and 2 should be fil.
Department of Health and Mental
Important: If item 27 is marked of any injury or other traumatic eve ပ္ Joseph P. Riley Frances Wiora 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 107 Mainsail Drive Stevensville, MD 21666 Susan Riley / Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Final Journey Crematory 02/09/2012 Woodbine, MD of Funeral Service I Signatu 22 Name and Address of Facility Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions. Examiner if any, leading to immediate Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed as the burial-trar signed by the attending physician and that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Day 4 ☐ Pregnant 9 ☐ Unknown 1 Yes 2 L 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic Obstructive Pulmonor Dis 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a Was an Within 24 hours after death.

To the Funeral Director: After this certificate has I autopsy performed? Yes 2 No prior to completion of cause of death? 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 🗌 Nursing Home 5 🔏 Residence 6 🗍 Other (Specify) 2 No 은 1 Inpatient 2 ER/Outpatient 3 DDA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 1 Natural 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check

State Registrar 29b, Signature and title of certifie

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death EBRUSE 650 2/012 М James Alexander Robertson 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Suburban Hospital Bethesda Montgomery Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Days Mir 088-18-9360 1 X M 2 🗆 F December 15, 1924 New York Usual Residence of Deceder 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland 1 X Yes 2 No Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? 419 Russell Avenue, #306 20877 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14, Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 X Yes 2 □ No If Yes, Give Year or Dates, Korea 1 ☐ Yes 2 👿 No Specify: 3 X Widowed 4 ☐ Divorced Specify: White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) International Elementary/Secondary (0-12) College (1-4 or 5+) 5+ Business Machines Physician 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Alexander George Robertson Jane Turpin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth Robertson / Daughter 7 Lantern Lane, Cherry Hill, New Jersey 08002 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State February Gate of Heaven Cemetery Silver Spring, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 11, 2012 21. Signature of Fysral Service Licenses Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850—2805 M01305 Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Respiratory Failure disease or condition resulting in death) Due to (or as a consequence of) Heparin Induced Thrombocytopenia Due to (or as a consequence of, Renal Failure Due to (or as a consequence of): Cardiac Heart Failure 23c. If yes, outcome of pregnancy 1 \square Live Birth 2 \square Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Dav Year Pregnant at time of death Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Aortic Valve Insufficiency, Coronary Artery Disease

Physician/ Medical **Examiner**

> and trar

> attending physician for use as the buria

the

signed by t d be detach

been signated by the second of

has page 2

certificate

After

ours after death.

Ieral Director: Aff

filled in by the fu

24 hours a

within 24 hou

To the Fune

completely fi

director

as

Physician/

þ

Completed

Be

|은

Certificate:

Medical

29b.

Hospital or Attending Physician: The law requires that the death certificate be executed

Box 68760

P.O.

Division of Vital Records,

Physician/

Medical

Examiner

Funeral

Director

show

28a-f

notified at

it. Page 1 and 2 should be filed within thrent of Health and Mental Hygiene reant: If item 27 is marked other the njury or other traumatic event, the

permit. Page 1: Department of I Important: If ite any injury or of

Director

Funeral

þ

Completed

Be

ည

10a. State

the Maryland

Maryland 21215-0036

Baltimore,

Sequentially list conditions If any, leading to himediate cause. Enter Underlying Cause (Disease or injury that initiated events Exami resulting in death) Last /Medical

IF FEMALE

27. Manner of Death

1 X Natural

Accident

Suicide

Homicide

5 Pending

Investigation

determined

6 Could not be

1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24a. Was an Were autopsy findings available autopsy performed? 1 Yes 2 X No prior to completion of cause of death?

Cardiomyopathy		
i. Was case referred to medical examiner?	M.W.	26. Place of Death (Check
1 ☐ Yes 2 X No	Hospital:	Other:

only one) 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury work?
1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number City or Town, State,

1 Yes 2 No

29a. Certifier (Check only one)	1 M Certifying Physician: To the best of my knowledge, death occur 2 Medical Examiner: On the basis of examination and/or investigatio 3 Certifying Nurse Practitioner: To the best of my knowledge, death	n, in my opinion, death occurred at the time, date	and place, and due to the cause(s) and manner state
29b. Signature and		29c. License number 20068474	29d. Date signed (<i>Month</i> , <i>Day</i> , <i>Year</i>) 2 - 7 - 20/2

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Michael Peter Siegenthaler. M.D. 8600 Old Georgetown Road, Bethesda, MD 20814

State Registrar 32. Registrar's Signature

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 03620 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death February 5, Physician/ 3:00 P M 2012 Kenneth Andrew Rehak, Sr. Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Baltimore 921 Essex Square **Baltimore** If Under 1 Year If Under 24 Hrs.
Months Davs Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 219-52-9081 1 🗷 M 2 🗆 F 64 Director Yrs 10/15/1947 Maryland Usual Residence of Deceder 28a-f shov 10d. Inside City Limits ms 23a or 28a-f shor must be notified at 10a. State 10b. County 10c. City, Town or Location 1 Yes 2 No Baltimore Maryland Baltimore 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 21221 U.S.A. 921 Essex Square 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status ed other than "natural", or iter event, the Medical Examiner Armed Forces? 1 Never Married 2XXMarried Yes þ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: White 3 Divorced 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4 or 5+) Elementary/Secondary (0-12) Steel Distributor Steel Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be fi Department of Health and Mental Important: If item 27 is marked any injury or other traumatic ev once. ည Lillian Fegelein Charles Rehak, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 921 Essex Square Baltimore, Maryland 21221 Barbara Rehak / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2XXCremation 3 Removal from State 2/6/2012 Towson, Maryland Hilltop Serv. Corp. 4 Donation 5 Other (Specify) 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. Towson, Maryland 21204 1050 York Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Due to (or as a consequence of): Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to for as a consequence of: attending physician and for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day 5 Other (specify) Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? 1 \square Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Natural Natural 5 Pending Accident Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basic of examination and/or investigation is a pro-Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of eath (Item 23a) (Type, Print) SAVITHA Ave TIMORIS 1124 mace

DHMH 17 Rev 06-2011

State Registrar

Rehak

Kenneth

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 | 2 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 9:00 P M ROSENZWEIG **FEBRUARY** 2012 HARRY LEWIS Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 719 DAVID AVENUE WESTMINSTER CARROLL If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In vrs. last birthday) **Funeral** Days Min Country) 1 X M 2 □ F 12721³/1939 Director 040-32-0503 72 CT Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If tem 27 is marked other than "natural", or items 23a or 28a-f shot any injury or other traumatic event, the Medical Examinar must ham material. 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State Director 1 Tes 2 No WESTMINSTER CARROLL 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 719 DAVID AVENUE 21157 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2X No Specify: Specify 3 Widowed 4 Divorced WHITE Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) 5+ Elementary/Seconday (0-12) MATH PROFESSOR **EDUCATION** Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျှ PHILIP ROSENZWEIG **GERTRUDE** 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) FRANCES ROSENZWEIG/WIFE 719 DAVID AVENUE, WESTMINSTER, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify BALTIMORE HEBREW CEM 02/08/2012 REISTERSTOWN, MD . Sion rur y of Funeral Service Lice 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Pancreati Immediate Cause (Final Physiciani 9ncer disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate

The Enter Inderlying

Cause (Disease or linjury Due to (or as a consequence of) that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Year a 🗌 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 No 3 Probably 4 Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perforn 1 Yes 2 76 25. Was case referred to medical 26. Place of Death (Check only one) examiner? ြု 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of De Certificate: 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Natural 5 Pending injury in 24 hours after ucc......he Funeral Director: Aft Accident Investigation 2 Accident
3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical 🙀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 038409

DHMH 17 Rev 7/2009

State

Registrar

30. Name and address of person

Day, Year)

FEB 08

31. Date filed (Month,

Falls Rd #415 Comeralle, MO, 21093

npleted cause of death (Item 23a) (Type, Print)

(0753

Sharfman

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 5 Day 2012 Feb. 12:15ам Gladys Asper Reed Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll Longview Nursing Home Manchester Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 - M 2 XF Months Days Hours Min coMaryland March 5, 1915 96 **Director** 220-34-6137 Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10d. Inside City Limits 10a, State 10c. City, Town or Location Director 1 🗌 Yes 2 🛛 No Marvland Baltimore Upperco 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21155 U.S.A. 3812 Black Rock Rd. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12 Was Decedent Ever in LLS 14. Race - American Indian Armed Forces Black, White, etc. 1 Never Married 2 Married Completed by 1 Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 Yes 2 No Specify. White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Cafeteria Worker High School Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Rosa Bosley James F. Shaffer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3812 Black Rock Rd. Upperco, MD. 21155 Janet Haines - daughter 20c. Location - City or Town, State 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 1 Surial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Zion Church Cem. Feb. 8,2012 Upperco, MD. Mt. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Eckhardt Funeral Chapel P.A Manchester, 3296 Charmil Dr. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Cause (Disease or linjury that initiated events resulting in death) Last requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FFMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Year Month Day Pregnant at time of death
Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ate has been signed I page 2 should be det Completed by 1 Tyes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law certificate has autopsy performe 1 ☐ Yes 2 ☐ No ☐ Yes 2 💢 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director, Hospital: Other: 2 X No မ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 \square Residence 6 \square Other (Specify) this Manner of Death . Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No Natural 5 Pending nours after death. neral Director, Aft I filled in by the fur Accident Investigation 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation is an examination and on the cause of examiners and on the cause of examiners and on the cause of examiners and on the cause of examiners and on the cause of examiners and one cause of e Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar (Item 23a) (Type, Print)

12-01041 Carl David Rvan Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

ouri buvia Nyar		1-For State Certificate of Death 2012	362
Physici Medical Exami	an/ ner	1. Decedent's Name (First, Middle, Last) Carl David Ryan 2. Date of Death Month Day Year February 4, 2012 3. Time of D 1028 h	
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 2557 Seamon Avenue 4c. County of Death Baltimore	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State	e or
Director		Z13-78-4613 1 1 M 2 F 52 Yrs. Months Days Hours Min. 5/18/59 Foreign Country) M	D
v any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside 0	
ryland a-f sbov	ţġ	MD ANNE Aruncle) Glen Burnie 1 Tyes 10e. Street and Number 10g. Citizen of What Country?	2 No
the Ma Sa or 28	Director		
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene. ont: If item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status 1 Never Married 2 Married 2 Married 12. Was Decedent Ever in U.S. 1 Never Married 2 Married 15. Was Decedent Ever in U.S. 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, B White, etc.	lack,
after de	J. F.	3 Wildowed 4 Divorced if the sine tear 1 Yes 2 M No specify: Speci	
72 hours a "natu			
0036 within within giene.	Completed	10 Driver Trucking 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)	
215- be filed intal Hyger- rked of	Be	William H. Ryan Barbara Arthur	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner	٩	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Shraden/Mother 312 Williams Rd. Glen Burnie, MD 2106	62
re, N s 1 and 2 f Health If item	1	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State	0 3
timo it. Page riment o	4	4 Donation 5 Other-Specify: Bayview Crematury 2/11/12 Baltmore, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Havi P. Close F. Svs., P.A.	V)
Balt permit. Depart Import injury		5126 Belain Road, Baltimone, MDZ1206	-5/05
Physician // Medical		23a. Fart I. Enter the 150 Se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. At homosocial are the cause of the ca	Onset and
Examiner		Immediate Cause (Final disease or condition resulting in death) a Atherosclerotic Cardiovascular Disease Due to (or as a consequence of):	
	ē	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):	
	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	
fox 68760, cath certificate be executed e attending physician and for use as the bunial - transit	CalE	d. I UNPENDED ☐ AMENDED 23a, 27, per me, g926 4-12-12 sm	X
760, icate be physiciathe buris	/Med	IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery	
X 68' th certifi	Physician/	250, vvas decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day 4 Pregnant at time of death 5 Other (Specify)	Year
Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: The law requires that the death certificate be executed thin 24 hours after death. the Funeral Director: After this certificate has been signed by the attending physician and natelety filled in by the funeral director, page 2 should be detached for use as the burial – transi	P S	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of d	leath?
S, P.(wires than n signed	ed by	1 Yes 2 No 3 Probably 4 VU	
cords law requir	Completed	24a. Was an 24b. Were autopsy findings autopsy periormed? death?	
tal Recions: The lactory page	S B B		No
of Vit. Physici er this c	라	1 Ves 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 V Other: Scene	
ion C tending leath. tor: Af	탏	27. Manner of Death 1 X Natural 5 Pending 2 Accident Investigation 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No	
Divisipital or At ours after dieral Direct filled in by	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) 28f. Location (Street and Number or Rural Route Num or Town, State)	nber, City
e Hospi 124 hou e Funer letely fil		1 298 Certifier . 1 1	
To the Hos within 24 h To the Fu	8		
		Theodon W. Kirk Things. O.C.M.E. February 5, 2012	
Kend		Name and address of person who completed cause of death (Item 23a) Theodore M. King, Jr., MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223	
Sta			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 | 2 Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 20:43 M O3^{pay} 2012 Physician/ Shipman Hubert Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 803 Wilbert Ave Baltimore Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth **Funeral** (Month, Day, Year) Months Hours 241-44-9799 Usual Residence of Decedent 1 🛛 M 2 🗆 F **Director** 03 25 34 NC 77 28a-f show 10d Inside City Limits 10c. City, Town or Location 10a. State the Medical Examiner must be notified at Director Yes 2 No MD NA Baltimore 10g. Citizen of What Country? 10e. Street and Number ö items 23a 803 Wilbert Ave 21212 U.S.A. death \ Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11, Marital Status Armed Force Black, White, etc. ò þ 1 Never Married 2 Married Yes **2**√ No Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Black If Yes, Give Year or Dates Specify: "natural", 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Carpet al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Business Owner 12th grade Be 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) and Mental F Maggie Campbell Cornelius Shipman other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 st Department of Health at Important: If item 27 is any injury or other trau 803 Wilbert Ave, Baltimore, Md 21212 Debra Pearson-Niece Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State 2/11/2012 4 ☐ Donation 5 ☐ Other (Specify) Whiteville, Md Cherry Grove 21. Signature of Funeral Service Licensee March F/H West 21215 Baltimore, 4300 Wabash Ave, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final HYPERTEN SION PULMOIVAR Phy i jan/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Exami Cause (Disease or injury that initiated events burial-trar resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical certificate be the as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy of or attending Physician: The law requires that the death after death.

Director: After this certificate has been signed by the atter in the past 12 months?
1 Yes 2 No Month Year Pregnant at time of death 5 Other (specify) signed by the at Id be detached fo P.0. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 1 Yes 2 No 3 Rrobably 4 Unknown Division of Vital Records, Completed plnods 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 Yes 2 No filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Na Residence 6 Other (Specify 2 No 1 🔲 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certificate: To 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending Investigation 2 Accident 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined To the Hospital within 24 hours a To the Funeral Completely filled Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

Registrar DHMH 17 Rev 06-2011

State

29b. Signature and title of certifier

31. Date filed (Month, Day, Year,

FEB 0 9 2012

Larakumar

30. Name and address of person who completed gause of death (Item 23a) (Type, Print)

RATAILUMAR, 506FLA 366

32. Registrar's Signature

5001

LOCH RAVEN BIVD , BALTIMORS

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2012 Marian Frances 10:15 February Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 13326 Turkey Branch Parkway Rockville Montgomery Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, July 5, Social Security Number 7. Age (In yrs. last birthday) **Funeral** Day, Year) 1927 **Director** 178-20-8340 Pennsylvania 1 □ M 2 🕱 F 84 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 No Rockville MD Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 13326 Turkey Branch Parkway 20853 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🛣 No
If Yes, Give by 1 Never Married 2X Married 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Joseph Fitzpatrick Loretta Rayburg 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9402 Highlander Blvd. Walkersville, MD 21793 19a. Informant's Name/Relationship (Type, Print) Wayne William Smith/son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crematory 02/08/12 Woodbine, MD

Phy i i n Medical Examiner

ned by the attending physician and
c detached for use as the burial-transit

within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-tra

Division of Vital Records, P.O. Box 68760

Hospital or Attending Physician: The law requires that the death certificate be executed

	21. Signat of Funeral Service License					ce P.O. I	30x 784 le MD 21029
		lications that caused the death. Do not e					Approximate Interval Between Onset and Death 4 1/2 years
Completed by Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of): C. Due to (or as a consequence of): d.					
nysician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3 4 Pregnant at time of death 5 9 Unknown	Ectopic preg			23d. Date of Month	delivery Day Year
ted by Pl	Part II. Other significant conditions co	ntributing to death but not resulting in the	e underlying caus	e given in Part I.			e to the cause of death?
Comple					24a. Was auto perfo 1 🗌 Yes	psy prior ormed? death	autopsy findings available to completion of cause of 1? Yes 2 No
Be	25. Was case referred to medical		2	. Place of Death (Che	ck only one)		
일	examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpat	ient 3 🗌 DOA	Other: 4 Nursing F	lome 5X Resi	dence 6 🗌 Other (S)	pecify)
Certificate:	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day, Year) 28b. Time injury	,	njury at vork? □ Yes 2 □ No	28d. Describe	how injury occurred	
	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, s building, etc. (Specify)	street, factory, off	ce	28f. Location (City or To	Street and Number or wn, State)	Rural Route Number,
Medical	(Check 2 Medical Examin	ician: To the best of my knowledge, deat ner: On the basis of examination and/or inv e Practitioner: To the best of my knowled	estigation, in my o	pinion, death occurred	at the time, date	and place, and due to t	he cause(s) and manner stated.
-	29b. Signature and title of certifier		29c. Lic	ense number		29d. Date signed (Mo	onth, Day, Year)
	1 Now		D458	80		February 6	, 2012

DHMH 17 Rev 06-2011

State Registrar Hwang, M.D. 1396 Piccard Drive Rockville, MD 20850

ess of person who completed cause of death (Item 23a) (Type, Print)

Christopher Stuchinski 12-00886 Please Unk Unk

2-00886		Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene	2 (
nk Unk		1- For State Certificate of Death Reg No.	4
Physicia Podical Exami	an/	Registrar 1. Decedent's Name (First, Middle, Last) Christopher Frank Stuchinski 2. Date of Death Month Day Year January 30, 2012 3. Time of Death 0914 hrs	
Tioai Exami		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 4d. County of Death 4d. County of Death 4d. City, Town, or Location of Death 4d. County of Death 4d. County of Death 4d. County of Death	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 X M 2 F 43 Yrs. The security Number 1 X M 2 F 43 43 43 43 45 43 45 45	nd
nd Chow any	_	Usual Residence of Decedent 10a. State	
th the Maryland 23a or 28a-f show notified at once.	Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21061 U.S.A.	
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f shomatic event, the Medical Examiner must be notified at once	Funeral	11. Marital Status 1	
136 thin 72 hours aff te. than "natural' edical Examine	Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Roofer Constitution (Give kind of work done during most of working life, DO NOT use retired) Roofing	
MD 21215-0036 12 should be filed within 72 hours th and Mental Hygiene. 127 is marked other than "natur umatic event, the Medical Exami	Be	17. Father's Name (First, Middle, Last) Joseph Frank Ross 18. Mother's Name (First, Middle, Maiden Surname) Doris G. Edwards	
MD 2' td 2 should dith and Me m 27 is my	ဥ	Linda Stuchinski / sister 304 Congressional Court Glen Burnie, MD. 21061	
Baltimore, MD 21215-C permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygi Important: If item 27 is marked oth injury or other traumatic event, the L		1 Burial 2 X cremation 3 Removal from State 4 Donation 5 Other Specify: A Donation 5 Other Specify: Bayview Crematory Crematory or other place) Bayview Crematory 02/04/2012 Baltimore, Maryland	d
Balti permit. Departn Import		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 2122 Approximate Internal Service of Part	25
Physician /Medical Examiner		failure. List only one cause on each line. Narcotic (Heroin) Intoxication complicated by Immediate Cause (Final disease a. drowning Between Onset ar Death	
	-	or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):	_
ed sait	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	
760, ficate be executed g physician and sthe burial - transit	cal	Mamended 23a,27,28a-f,per me,g924 2-15-12 sm	
66 certi ndin	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (Specify) 9 Unknown	
P.O. BO: es that the deati igned by the atr oe detached for	Ď	Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Vunknow	'n
cords, law requir has been s	Completed	24a. Was an autopsy findings availa prior to completion of cause of death? 1 ✓ Yes 2 No 1 ✓ Yes 2 No	
ital Rec ician: The s certificate rector, page	Be	25. Was case referred to medical examiner? A Silver 2 Na Hospital: Inpatient 2 ER/Outpatient 3 DOA Other: Scene	
on of Vi ading Phys th. Ther this	ion: To	27 Means 1 No 280 Date of Journ 28h Time of Injury 28c Injury at Work? 28d Describe how injury occurred	
Divisior septed or Attend hours after death meral Director:	Certification:	2 Accident Investigation 3 Suicide 4 Homicide 4	ity D •
Di To the Hospital within 24 hours: To the Funeral completely filled	Medical Co	29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	
T with	₩ We	29b Signature and title of certifier 29c. License number O.C.M.E. 29d. Date signed (Month, Day, Year) January 31, 2012	
ф		30. Name and address of person who completed cause of death (Item 23a) Laron Locke MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223	Ī
S Regis	tate strar	31. Date Mind (Month, Dev Year) 32. Registrar's Signature	
itegis	44.1		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ 7, 2012 9:15 Ам Shih February Thomas Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bethesda Montgomery 6820 Marbury Road 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Hours Min 569-80-4412 Director 1 🛛 M 2 □ F 72 July 10, 1939 China Usual Residence of Deceden or 28a-f show notified at 0a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🛛 No Maryland Montgomery Bethesda 9 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be n United States 6820 Marbury Road 20817 items within 72 hours after death 12. Was Decedent Ever in U.S.
Armed Forces?
1 ☐ Yes 2 ⚠ No
If Yes, Give
Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Black, White, etc. 9 þ 1 Never Married 2 X Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify. "natural" 3 Widowed 4 Divorced Completed Asian Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working than, National Institutes life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the 5+ of Health Scientist other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F is marked of ပ traumatic Kuan-Cheng Shih Bin-Er Chen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other traconce. Ming-Chuen Shih / Wife 6820 Marbury Road, Bethesda, Maryland 20817 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State February 14, cemetery, crematory or other place) 1 🛛 Burial 2 🗆 Cremation 3 🗆 Removal from State 2012 4 ☐ Donation 5 ☐ Other (Specify) Parklawn Memorial Park Rockville, Maryland 21. Signature of Funeral Service Licensee Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. Hospothus M01360 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between 3 Gentle Death Immediate Cause (Final Physician MULTIFORME (SLIOBLASTOMA disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Due to or as a conse juence of cause. Enter Underlying Cause (Disease or injury burial-transit and that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No Month Dav Year 4 ☐ Pregnant at time of death 9 ☐ Unknown been signed by the a should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No certificate 1 ☐ Yes 2 ☐ No the funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Other: al or Attending Physics after death.
I Director: After this o ျပ 1 Inpatient 2 Inpatient 3 Inpatient 3 Inpatient 2 Inpatient 3 Inpa 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred Certificate: 1X Natural 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined To the Hospital or within 24 hours af To the Funeral Di completely filled in Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier

State Registrar 1550 ORUFANS ST, CRB2/M-16, BALTO, MD 21287

completed cause of death (Item 23a) (Type, Print)

6NO

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 955AM Sharon Deborah Sparr Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** N/A Baltimore Union Memorial Hospital Year If Under 24 Hrs Birthplace (State or Foreign Country) 5. Social Security Number Age (In yrs. last birthday) **Funeral** Months Hours (Month, Dav. Year) Director 215-76-1624 1 🗆 M 2 🗶 F Yrs 56 1955 AUG 5. Washington 28a-f show 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10b. County Director 1 X Yes 2 No MD N/A Baltimore 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral 21231 21 North Chester Street USA 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian. Armed Forces?

1 Yes 2 XNo Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 👿 No Specify Specify: "natural", 3 Widowed 4 X Divorced White Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d Mental Hygiene. marked other than Elementary/Secondary (0-12) 12 College (1-4 or 5+) Child Care Nanny Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Tucholka Joseph James Sparr Margaret 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i 502 South Milton Avenue Baltimore, MD 21224 Derek Knight, son other 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 20c. Location - City or Town, State Page 1 9 1 Burial 2 X Cremation 3 Removal from State Department of Important: If any injury or Metro Crematory, Inc. 02/08/12 4 Donation 5 Other (Specify) Baltimore, MD permit. 21. Signature of Funeral Service Licensee George MacNabb 22. Name and Address of Facility Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ BOWEL PERFORATION disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner LUNG CANCER NON SMALL if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine physician and s the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ed by the atter in the past 12 months?
1 Yes 2 No Month Dav Year Pregnant at time of death 5 Other (specify) 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Unknown the Hospital or Attending Physician: The law requires that the signed by t d be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate has performed? 1 Yes 2 No the funeral director, 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) ည 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Funeral Director: After injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier within 24 hor To the Fune completely fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2

Registrar

VRINDA MAHAJAN 31. Date filed (Month, Day, Year) State

only one)

29b. Signature and title of certifier · vmalajan

FEB 0 9 2012

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D70031

201 E. UNIVERSITY PARKWAY BALTIMORE

		1	For State		State	of Mar	yland		irtment of tificate of			1ental Hy		20	12	036	29
			Registrar 1. Decedent's Name (First,	Middle, Last,)	_			incate of	Deati		2. Date of De			I bus	3. Time of Deat	th
Physic Me	cian/ dica	_		Ве	tty I	Tujit	a Si	hima				Februa	ry 5,	201	ear 2	1:56 A	A M
Exan	nineı	r 4	4a. Facility Name (if not inst Shady Grove				ital		4b. City, Town, Rock	or Locatio				County of Monts		ry	
Funer	al	4.	5. Social Security Number	6. Sex			n yrs. last	birthday)	If Under 1 Year Months Day	ır If Unc	ler 24 Hrs.	8. Date of Bi		9	B. Birthp	lace (State or For	reign
Direct	100	ŀ	575-16-9956 Usual Residence of Dece		□ M 2 X F	8	9	Yrs.	World S Day	- Hours	14/11/1	December		922	Hawa	**	
land show dat	\$	3	10a. State 10b. C			1	0c. City, T	own or Loc							10	Od. Inside City Lin	mits
e Mary r 28a-1 notifie	Disposi		Maryland Maryland Maryland	lontgon	nery			Gait	hersbur 10f. Zip Code				10 000	zen of Wh		1 X Yes 2 L	No
with the 23a of 1st be	100		415 Russell	Aveni	ıe. #10	005				877			- 0	ed St		2	
death items	Loronia		11. Marital Status		12. Was Dec	edent Eve			Vas Decedent of Yes, specify Cu				-	14. Race -	America White, e		
036 s after ral", or Exami	3	20 Dy	1 ☐ Never Married 2 ☐ 3 ☐ Widowed 4 ☐ Dir		1 ☐ Yes If Yes, Gi Year or D		0	1	☐ Yes 2 🕅 1	No Speci	ify:			Specify:	Asi		
21215-0036 within 72 hours after giene. er than "natural", o t, the Medical Exam	Totolamo,	ומובו		ecedent's Ed highest grad	ucation de completed)		(Give k	ent's Usual Occ ind of work don	e during m	ost of work	ing	16b. Ki	nd of Busi	ness/Ind	lustry	
2121 vithin 7 liene. or than	1	5	Elementary/Secondary (0-12)	College (1-4 or 5+)			NOT use retire maker	d)			Ow	n Hoi	me		
ind:	9		17. Father's Name (First, Mi		• • .						other's Nam	e (First, Middle	, Maiden S	Surname)			
Maryland 2 should be filed Ith and Mental Hy 27 is marked oth traumatic event		1	Shusaku Ota 19a. Informant's Name/Rel				T	10h Mailin	g Address (Stree		_		er City or	Town Stat	e Zin C	ode)	
, Ma nd 2 sh salth ar n 27 is er trau		1	Terry T. Sh			nd		415 R	ussell .	Avenu	e, #1	005, Ga	aithe	rsbur	g,	MD 20877	
ge 1 ar nt of He or oth		[20a. Method of Disposition 1 ☐ Burial 2 🛣 Cren			n State	Month	eomer	sition (Name of natory or other p	lace)	Febr			cation - Ci	-		
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at	60	ŀ	4 ☐ Donation ☐ C 21. Signature of Fyrn ral Se				Crema	atori	um, Inc	•	9, 2		1			aryland	_
a m E	once	1	yngritte	Bann	us0		01305							, Mary	land	20850-280	5
		1	23a. Part / Enter the dises shock, or heart failure Immediate Cause (Final	ase, or comp . List only on	lications that e cause on e	ach line.	ì		r the mode of d	ying, such	as cardiac (or respiratory a	rrest,			Approximate Interval Between Onset and Death	
- Physicia Medic	al	1	disease or condition resulting in death)		a. <u>65</u> Due to		tov onsequen		-allu	10					+		
Examin			Sequentially list conditions	, I	b. bil		val		eumon	ia							
ted	Fyaminar		if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	•	CLCA	ute	ionsequeri MV/	n CON	dial i	ntar	ctio	n					
60 ate be executed hysician and the burial-transit	\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	LY	that initiated events resulting in death) Last		1	(or as a c	onsequen	ice of):				-					
760 ate be physici	legipa				d. <u>me</u> 7	25	tati	C 10	ng ca	ncer					\pm		
P.O. Box 68760 that the death certificate be executed ned by the attending physician and edetached for use as the burial-transi	Dhyeicician/Mo		IF FEMALE; 23b. Was decedent pregna	III.	23c. If yes, ou] Ectopic pregna	ancy				23d. Date	of delive	ry	
BOy death the atte	1.0	33101	in the past 12 months' 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	?		gnant at t	ime of dea		Other (specify)		-			Month	٦	Day Year	
Division of Vital Records, P.O. Bc To the Hospital or Attending Physician: The law requires that the dea within 24 hours after death. To the Funeral Director: After this certificate has been signed by the a completely filled in by the funeral director, page 2 should be detached f	5. D. D. D. D. D. D. D. D. D. D. D. D. D.		Part II. Other significant c	onditions co	ntributing to	death but	not resulti	ing in the u	nderlying cause	given in Pa	art I.	23e. Did	tob <i>a</i> cco u	se contrib	ute to th	e cause of death?	?
ords, requires been sign should be	12											1 🗆	Yes 2 [□ No 3	☐ Prob	ably 4 🕻 Unkn	nown
Division of Vital Records, tal or Attending Physician: The law requires rs after death. al Director: After this certificate has been signed in by the funeral director, page 2 should be	potologo											24a. Was	s an opsy formed?	pric	re autop or to cor ath?	sy findings availa npletion of cause	able e of
of Vital Reco Physician: The law this certificate has ral director, page 2	000		25. Was case referred to m	edical					26.	Place of D	eath (Chec	1 \sum Yes	2 2 No	1 [Yes	2 No	
Vita hysicia his cer al direc	12	2	examiner? 1 🗌 Yes 2 🛣 No	F	_				t 3 🗆 DOA	other: 4	Nursing Ho	ome 5 🗆 Res	idence 6	Other (Specify)		
n of ding P th. After t	100	916		Pending Investigation	28a. Date (Mor	e of injury oth, Day, '		Bb. Time of injury		jury at ork? □ Yes 2		28d. Describe	how injury	occurred /			
iSiO Atten er deal ector: by the	otorii:		3 Suicide 6	Could not be determined	28e. Place	e of Injury ling, etc. (- At home	e, farm, stre	eet, factory, offic				(Street and		or Rural	Route Number,	
Division of hospital or Attending Ph hours after death. Funeral Director: After thistely filled in by the funeral			1 70	Aifeir Dhon				ac dooth o	and the state of t	ione elete e	nd place o				ac state	nd	
To the Hospital Within 24 hours of To the Funeral I completely filled	Modioal) near	(Check 2 Me	dical Examir dical Examir difying Nurs	ner: On the ba e Practitione	sis of exa er: To the b	mination ar pest of my l	nd/or invest knowledge,	occurred at the t igation, in my op death occurred	inion, death at the time,	n occurred a date and pl	t the time, date ace, and due to	and place, the cause	, and due to (s) and mar	the cau	use(s) and manner tated.	stated.
To the vithing complete the com	•		29b. Signature and title of	Confident Confidence C		m	n		29c. Lice	nse numbe	er C 1		29d. Dat	e signed (/	Month, L	Day, Year)	
		-	30. Name and address of p	areon who or	ompleted cau	ise of dea	th (Item 23	Sa) (Type P	rint)) 4 13	76		1-00	Mar	161	7017	
		-	Sonia John	n MD	9901	Me	dian	(Cer	iter 7	rive,	Ro	deville,	, Mo	ny la	nd	se(s) and manner tated. Day, Year) 20 ()	
S Regis	state strar		31. Date file FEB, Cay	2012	32.1	Registrar'	s Signature	back									
DHMH 17 Rev					7-51												

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ February 3, 2012 Byron Μ. Stepek 5:15 Рм Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 7902 Pearlbush Drive #104 Gaithersburg Montgomery If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Hours 212-72-9794 Director 1 X M 2 □ F 56 April 19, 1955 Washington, D.C. 23a or 28a-f show 10c. City, Town or Location the Medical Examiner must be notified at Director 1 Yes 2 X No Maryland Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7902 Pearlbush Drive, #104 20879 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 Yes 2 X No Black, White, etc. 1 X Never Married 2 Married "natural", or þ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates White 3 Divorced 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working and Mental Hygiene. is marked other than Elementary/Secondary (0-12) life. DO NOT use retired) College (1-4 or 5+) Trucking Driver injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Teddy Clarkson Thaddeus Stepek 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other tra. 16616 South Westland Drive, Gaithersburg, MD 20877 John Stepek /Brother 20b. Place of Disposition (Name of Monday Commercy or other place) Crematorium, Inc. 20a. Method of Disposition 20c. Location - City or Town, State February 1 Deurial 2 X Cremation 3 Demoval from State Bethesda, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 9, 2012 of Fundral Service Lifensee Robert A. Pumphrey Funeral Home/Rockville, Inc. M01305 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 Inter the disease, or complications that caused the death, Do not enter the mode of dving, such as cardiac or respiratory arrest, Interval Between Onset and Death or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Physician/ 164 1200 41V Medical resulting in death) Examiner Sequentially list conditions, in any, locating to immediate cause. Enter Underlying Examiner Due to for as a consequence of: Cause (Disease or injury that initiated events and -trar Due to (or as a consequence of): resulting in death) Last Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) Yes 2 No 1 Yes 2 9 Unknown 9 Unknown cate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 1 Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 2 No ည 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 IDOA this funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a

To the Funeral C

completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner 29b Signature and title of certifie MODME who completed cause of death (Item 23a) (Type, Print)

Registrar

State

		_ State	State of Marylar		artment of I tificate of I		and M			2012	03631
		Registrar 1. Decedent's Name (First, Middle, Last)		061	tincate of t	Jeann		2. Date of Dea			3. Time of Death
Physici Med		Miltiadis		_5te	fadour			Februa	Day Lo	2012	19 40°M
Exami	ner	4a. Facility Name (if not institution, give str			4b. City, Town, o		of Death		4c. C	ounty of Death	
Funera	_	5. Social Security Number 6. Sex	7. Age (In yrs. I	ast birthday)	If Under 1 Year Months Days	If Under Hours	24 Hrs. Min.	8. Date of Birt (Month, Day	h v, Year)	9. Birth Cour	place (State or Foreign
Directoi		Usual Residence of Decedent	M 2 □ F 72	Yrs.				April 2	24, 19	39 Gree	ece
ryland -f sho	Director	10a. State 10b. County		y, Town or Loc							10d. Inside City Limits 1 ☐ Yes 2 🖾 No
the Ma or 28a or or 1	Dire	Maryland Montgome 10e. Street and Number	ery	Chevy	Chase 10f. Zip Code				10a. Citize	en of What Cou	
n with test sa	Funeral	5500 Friendship B	lvd. Apt. 15	1 ON	20	815				ed Stat	•
Iryland 21215-0036 ould be filed within 72 hours after death with the Maryland to Mental Hygiene. marked other than "natural", or items 23a or 28a-f show matic event, the Medical Examiner must be notified at	क्र	11. Marital Status 1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced	2. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give	l1	Vas Decedent of F f Yes, specify Cuba Yes 2 X No	an, Mexican	n, Puerto F	cify Yes or No- Rican, etc.)		4. Race - Americ Black, White, pec <i>ify:</i> Wh	
hours	letec	15. Decedent's Educ		16a. Decec	lent's Usual Occup	oation				d of Business/Ir	
21215-0036 within 72 hours after giene. er than "natural", o	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do	kind of work done O NOT use retired)	during most	t of workin	ng	ш		
led wit I Hygie other	Be	17. Father's Name (First, Middle, Last)	J+	Card	iologist	18. Mothe	er's Name	(First, Middle,		ospital urname)	
ylan Id be fi Mental arked atic ev	은	Anargyros Stefado	uros			Chr	rysou	la Bous	sioti	S	
Ma 2 sh th ar th ar trau		19a. Informant's Name/Relationship (Type Frederique Stefado			ng Address (Street				-		Code) y land 20815
Te, 1 and of Heal item		20a. Method of Disposition	20b. F	Place of Dispo	sition (Name of natory or other place		Febru	-		ation - City or T	
Baltimore, bermit. Page 1 and Department of Hea Important: If item any injury or othe		1 X Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	Jilloval Ilolli Otato		ven Cemete		10, 2		Silver	r Spring,	Maryland
Baltimo permit. Page Department of Important: If any injury or once.	Į.	21. Sign of Fundal Service Licensee	10 MO1	305 R ²² 75.	Name and Addre bert A. Pur 57 Wiscons:	ss of Facilit iphrey in Aven	Funera	al Home/ ethesda,	Bethes Maryl	da-Chevy and 20814	Chase, Inc.
		23a. Part 1 Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final	ations that caused the deat cause on each line.	h. Do not ente	er the mode of dyir	ng, such as	cardiac or	respiratory an	rest,		Approximate Interval Between Onset and Death
Physician Medica		disease or condition resulting in death)	Due to as a conseq		Cancer						
Examine		Sequentially list conditions, b.									
ted	Examiner	if any, leading to immediate	Due to (or as a conseq	uence of):						-	
execu ian and urial-tra		that initiated events c. resulting in death) Last	Due to (or as a conseq	uence of):							
/60 cate be executed physician and s the burial-transit	edical	d.									
certific	M/ME	Zoo. Was accedent pregnant	c. If yes, outcome of pregna	ancy	Totonia praenen				23	3d. Date of deliv	ery
cords, P.O. Box 68760 law requires that the death certificate be executed has been signed by the attending physician and e.2 should be detached for use as the burial-transi	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 Pregnant at time of 9 Unknown		Other (specify)	Су				Month	Day Year
that the	by Ph	Part II. Other significant conditions cont	ributing to death but not res	sulting in the u	nderlying cause gi	ven in Part	I.	23e. Did to	obacco use	e contribute to t	he cause of death?
dS, equires een sig lould b								1 💢	Yes 2	No 3 🗆 Pro	bably 4 Unknown
ecol	Completed							24a. Was autop	osv		ppsy findings available empletion of cause of
Vital Hecords, ysician: The law requires is certificate has been sig director, page 2 should b	Be Co	25. Was case referred to medical			26. P	lace of Dea	ath (Check		rmed? 2 X No	1 🗌 Yes	2 No
hysici his cer al direc	은	T Yes 2 🗛 No	spital: 1 🗶 Inpatient 2 🗆		nt 3 🗆 DOA Oth	or.			dence 6	Other (Specif	y)
on of Vital F nding Physician: T ath. : After this certifica e funeral director, p	cate:	27. Manner of Death 1 X Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day, Year)	28b. Time of injury	wor	ryat k?]Yes 2. □		8d. Describe h	iow injury o	occurred	
Division of Vital To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Certificate:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, stre		. 100 2 2		28f. Location (S		Number or Rura	Route Number,
pital or ours aft eral Diri		On the state of th									
ne Hos n 24 ho ne Fune oletely	Medical	(Check 2 Medical Examine	an: To the best of my know r: On the basis of examinatio Practitioner: To the best of I	n and/or invest	igation, in my opini	on, death oc	ccurred at t	the time, date a	ind place, a	and due to the ca	use(s) and manner stated
To the To the Comp		29b. Signature and title of certifier		, , ,	29c. Licens		· ·			signed (Month,	
		Isilos hilyt	ENT MD	22 \ 5	RES	000)	1	Febr	UWY	10 2012
		30. Name and address of person who com		n 23a) (Type, F	rint)	lo/to	SLR	altimo	77. H	lamular	d 21287
St Regist	ate rar	31. Date filed (Month, Day, Year) FEB 0 9 2012	32 Registrar's Signa	ture			-			7.00	

X DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Day 5 Month Physician/ herine 08:34 AM 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Parkville Morningside House 1 Year If Under 24 Hrs. 5. Social Security Number If Under 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 🖵 F 84 Mary Land 220-18-6608 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shon any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10a. State Director 1 ☐ Yes 2 No MD Baltimore Nottingham 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral U.S.A. 21236 3 Kristal Court 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Specify: White Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Katherine Kaiser Ρ. Hannan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3 Kristal Court, Nottingham, MD John P. Thaler-son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 🗓 Burial 2 🗆 Cremation 3 🗔 Removal from State John's Cemetery 2/8/12 Hydes, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Ruck Towson Funeral Home, Inc. Towson. MD 23a. Part 1. Enter the disease, or computations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death
O (O) ZOOS Immediate Cause (Final Ph sician/ mer disease or condition Medical resulting in death) to (or as a consequence of) Examiner nen 01012008 Sequentially list conditions, Examiner if any, reading to himsediate cause. Enter Underlying completed filled in by the funeral director, page 2 should be detached for use as the burial-transf Cause (Disease or iinjury that initiated events resulting in death) Last 01012008 Due to (or as a consequence of) Physician/Medical 014/2008 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregrant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 mg Month Day Year Pregnant at time of death 9 Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 1 🗌 Yes 2 No Yes 25. Was case referred to medical examiner? Place of Death (Check only one) Be Hospital 2 No မ 1 Tyes 1 Inpatient 2 I ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 27. Mann f Death 28b. Time of 28a. Date of injury (Month, Day, Year) 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No Natural 5 Pending Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State)

the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 within 24 hours after death.

To the Funeral Director: After this certificate has

Signature Name and addless of person who completed cause of death (Item 23a) (Type, Print) MP. CRNP, MIN

🖟 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

State

31. Date fited (Month, Day, Year) FEB 0 9 2012

29a. Certifier

(Check

only one)

32. Registral s Signature

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#20b perFH, G924, 2/9/2012 WS
State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month Year 11:43PM Physician/ STEPHEN LEE UNGER Medical Facility Name (if not institution, give street and number) 4b. City Town or Location of Death 4c. County of Death **Examiner** B. Himire CiF Hospital N/A 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. Social Security Number UNK 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Days Hours Director 1 🕅 M 2 🗆 F 06/01/1937 NY 74 Usual Residence of Deced or 28a-f show 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits must be notified at Director 1 Yes 2 X No BALTIMORE OWINGS MILLS MD 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a Funeral UNK ASSOCIATED WAY 21117 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status traumatic event, the Medical Examiner Black, White, etc. 1 ☐ Yes 2 🔀 No If Yes, Give or by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify Specify: "natural", Completed 3 Widowed 4 X Divorced Year or Dates WHITE 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d be filed within 72.

Aental Hygiene.

Irked other than "r Elementary/Secondary (0-12) College (1-4 or 5+) SPORTS HANDICAPPING 3 SALES Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) marked ဂ္ FRIEDMAN ALBERT UNGER FRIEDA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 12326-A PARK HEIGHTS AVENUE, OWINGS MILLS, MD 21117 ANDREW UNGER/SON or other 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Department of Important: If it any injury or o once. letery crematory or other place)
LINGTON CEMETERY
IZUK AMUNO CONG. 1 Burial 2 Cremation 3 Removal from State 02/01/2012 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., Matt Lev. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. nd Death Immediate Cause (Final Physician/ Due to (or as a con. quence f): disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physiciar Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Day Pregnant at time of death Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed by 2 SNo 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available 24a. Was an autopsy performs of?

1 Yes 2 No page 2 s prior to completion of cause of death? has 1 L Yes funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? P Hospital Other: 1 Tes 1 | Inpatient 2 | ER/Outpatient 3 | DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death To the Hospital or Attending Ph within 24 hours after death.

To the Funeral Director: After th completely filled in by the funeral Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29c. License number 29b. Signature and title DOO 63298 rson who completed cause of death (Item 23a) (Type, Print 30. Name and addr

M DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year)

FEB 0

12-00991 Robert E. Vaughan

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2012 03	6	3	L
---------	---	---	---

		1- For State Registrar		Certi	ificate of	Death		F	Reg. No.) i L 0000		
Physicia	ın/	1. Decedent's Name (First, Mid-					Date of De Month	Day Yea	3. Time of Death 1422 hrs			
Modical Exami	ner		Robert E. Vaughan acility Name (if not institution, give street and number) 4b. City, Town, or Location of De					rebluary 2, 2012				
		4a. Facility Name (if not institution, give street and number) 1315 Chesaco Aven∪e #321				Rosedale	Location of Dea		4c. County of Death Baltimore County			
Funeral		5. Social Security Number	Age (In yrs. Ias	(In yrs. last birthday) If Under 1 Year If Under 24I Months Days Hours In			flin		9. Birthplace (State or Foreign			
Director	Į	215-32-9150	1 X M 2 F	75	Yrs.	Monard Baye	1.00.0	May 2	29, 1936	countryMaryland		
b		Usual Residence of Decedent 10a. State 10b. County		10c City T	own or Location	ın.	_			10d, Inside City Limits		
ow any	ctor		imore	711	edale					1 Yes 2 No		
yland t-f sh		10e. Street and Number	riiore	ROS	edate	10f. Zip Code			10g. Citizen of Wh			
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show injury or other traumatic event, the Medical Examiner must be notified at once.	Director	1315 Chesaco	Ave. #321			21237				JSA		
n with	Funeral	11. Marital Status	12. Was Decede			Decedent of Hisp s, specify Cuban,			lo- 14, Race White	- American Indian, Black,		
r deat or ite	딆	1 X Never Married 2 N	1 Yes	2 No				,		White		
s afte	ā		vorced If Yes, Give Year or Dates:	omploted) 1		Yes 2 X No	specify:	of work done	Specify: 16b. Kind of Bus			
hour "natu	ted	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)				st of working life.						
36 hin 72 e. than	Completed by	12 Warehouse					Manufacturing					
d with	등	17. Father's Name (First, Middle	e, Last)			1	8.Mother's Nar	me (First, Middle,	, Maiden Surname)			
21215-0036 suld be filed within 7 Mental Hygiene, marked other than ic event, the Medica	Be	Robert E. Va					Marj	orie W	ills			
21 nould and Meris man	입	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or To										
MD nd 2 sho alth and m 27 is		Roberta Vaugh	an/ Sister	Look Bu				#4205]		n, NV. 89002 City or Town, State		
S l an of Hea		20a. Method of Disposition 1 Burial 2 X Crematic	n 3 Removal from		ace of Disposite matory or other	ion (Name of cem er place)	netery,	Date	20c. Location -	City or Town, State		
Page nent or oth	ı	4 Donation 5 Other 5	Specify:	Hil		ervice C		·9 - 12		on, MD.		
Baltimore, oernit. Pages I an Department of Hes important: If ite		21. Signaturo / Funeral Vervic	Livinsee		22. Na	ime and Address, RUCK	of Facility IOWSON	Funeral	Home, Ir	nc.		
		23a Part Fotor the disease of	complications that cause	ed the death C		1050	York Ko	l. LOWSO	n. MD. 23	LZU4		
Physician /Medical		failure. List only one cause on each line.								Between Onset and Death		
Examiner		Immediate Cause (Final diseas or condition resulting in death)	Due to (or as a co							, see a see		
		Sequentially list conditions	b.									
	<u>e</u>	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause										
	(Disease or injury that initiated											
uted nd ransit	<u>آ</u> ا		d									
760, ficate be executed g physician and the burial - transit	dica	UNPENDED	AMENDED									
760, icate be physici the burn	₹	IF FEMALE:	23c. If yes, out						23d. Date of			
68 certifi nding se as							Day Year					
Box 687 e death certification attending a	Physician	1 Yes 2 No 9 U	nknown 9 Unknown		5 Oth	er (Specify)		4	1			
that the death certificate by the attending detached for use as		Part II. Other significant cond	tions contributing to de	ath but not res	ulting in the un	derlying cause gi	ven in Part I.	23e. Did	tobacco use contril	bute to the cause of death?		
res the	d b							_ 1 □ Y€	es 2 🗸 No 3	Probably 4 Unknown		
Vital Records, ysician: The law requi	Completed							24a. Was		Vere autopsy findings available rior to completion of cause of		
eco ne law te has ge 2 s	틹							perf	ormed? d	eath? Yes 2 No		
tal Rection: The certificate ector, page		25. Was case referred to medic	al			26.Place	of Death (Chec					
Vita ysicis direct	o Be	examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpa	atient 2 E	R/Outpatient	3 DOA	Other Nur	sing Home 5	Residence 6	esidence 6 🗸 Other: Scene		
ing Ph		27, Manner of Death	28a. Date of I	njury 2 y,Year)	8b. Time of In		y at Work?	28d. Describe Subject sh	how injury occurre	ed		
ion tendi eath. the fi	랿		estigation FOUND: Feb 2, 201:		FOUND: 1418 hrs	1 Y	es 2 🗸 No	Oubject 311	ot sen			
Division of Vital Records, P.O. pital or Attending Physician: The law requires that th ours after death. eral Director: After this certificate has been signed by filled in by the funeral director, page 2 should be detach	tific	3 ✓ Suicide 6 Cou	ld not be 28e. Place of			, factory, office bu	uilding, etc.	or Town,	State)	er or Rural Route Number, City		
Dispital cours a filled filled	Certification:	4 Homicide	ermined (Specify)	/lulti-Family	Apt.			1315 Chesa	co Avenue #321,	, Rosedale, MD		
Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certifi within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as												
To t To t com	Medical	29b. Signature and title of certif	and manner state		-	29c. License				ed (Month, Day, Year)		
	_	/V c. D. D.	(1111)			O.C.N	M.E.		February 3,	, 2012		
VI	-	30. Name and address of person	n who completed cause of	of death (Item ?	3a)							
11			Assistant Medical E			timore Street	, Baltimore	, MD 21223				
St	ate	31. Date flied (Month, Day Year	32. Regis	trar's Signature			·		 .			
Regist	rar	LER 0 8 5015	Cleven	B. 100	we							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 7 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 02 Physician/ 03 2012 23:30 PMM Dolores J. Wehrman Medical 4a. Facility Name (if not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Upper Chesapeake Medical Center Bel Air Harford If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Hours (Month, Day, Year) 220-36-3395 Usual Residence of Deced **Director** 1 🗆 M 2 💢 F 07/27/1935 Maryland 76 Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 🗌 Yes 2 😾 No MD Baltimore Baldwin 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 4928 Carroll Manor Road 21013 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?
1 Yes 2 No Black, White, etc. þ 1 Never Married 2 XMarried 1 Yes 2 X No Specify. If Yes, Give Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Baltimore County Elementary/Secondary (0-12) College (1-4 or 5+) Public School System Teacher Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental is marked Maud L. Ensor Walter J. Jenkins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4928 Carroll Manor Road - Baldwin, Maryland William G. Wehrman (husband) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Wilson U.M.Church Cem. 02/08/2012 | Long Green, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. ng at le of Funeral Service Licensee <u> 11750 Belair Road - Kingsville, Maryland</u> Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, Immediate Cause (Final DEPTIC Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): 24 Hoses Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 68760 that the death certificate 23d. Date of delivery 23b. Was decedent pregnant Box in the past 12 months?

1 Yes 2 No P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ DIVERTICULITIS 1 Yes 2 No 3 Probably 4 Nnknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes → No Congestive WRART 24a. Was an autopsy performed Yes 2 I or Attending Physician: after death.
Director: After this certifications Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ne Hospital on 24 hours af e Funeral Di Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Curtifying N ordy one 29d. Date signed (Month, Day, Year) 29b. Signature and ti DOC56296 2-4-2012 son who completed cause of death (Item 23a) (Type, Print) Jason Birnboum 500 upper Chosopeake Dr Bel Air, MO 21014

Registrar

80509

Maryland 21215-0036 Baltimore, that the death certificate be executed Box 68760 law requires Records, **Division of Vital**

Amend Item 24a per verb., g924,02/09/2012dhb
Certificate of Death

State of Maryland / Department of Health and Mental Hygiene 2 0
Certificate of Death

Reg. No. For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ Month Year DONALD WENDERUTH 2012 INIC Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner County of Death FUAD MANGE CARE WEST 102500 TIMORE 5. Social Security Number If Under 24 Hrs. If Under 1 Year 6. Sex 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Age (In yrs. last birthday) **Funeral** 1 M 2 D F Months Days Hours Min. Yrs. **Director** 11-16-28 216-24-7470 Usual Residence of Decedent or 28a-f show notified at 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 📑 No MD 100500 0 10e. Street and Numbe 10f. Zip Code 10g, Citizen of What Country? pe items 23a Funeral USA CJEST 21204 111 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. , or ģ 1 Never Married 2 Married within 72 hours after 1 Yes 2 No Specify Specify: WIH ITE "natural" Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) MINANCE BANKING Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ith and Mental I 27 is marked o traumatic eve ည Smans WENDERUTH UNKNOWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . Page 1 and 2 shament of Health a 27 KUSSZCE KD WENDEROTH 7805 TRIEL MD Department of Heall Important: If item 2 any injury or other once. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) CREMATORY MI 10-2012 Signature of Funeral Service Licensee 22. Name and Address of Facility 2829 HUDIEN ST. SKARDA FLUERA BAL TIMERE MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause og Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? for Day Year Pregnant at time of death 2 🗌 No 1 | Yes 2 | g | Unknown detached g Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? Yes 2 No page 2 this certificate 1 Yes 2 No Physician: 25. Was case referred to medical funeral director. Be 26. Place of Death (Check only one) Other 4 Nursing Home 5 Residence 6 Other (Specify, Hospital: 2- No 2 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred Hospital or Attending After injury →1 ■ Natural 5 Pending Investigation 2 Accident
3 Suicide
4 Homicide Accident Director: Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by determined 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the pest of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F only one) 29b. Signature at of certifier 30. Name and address of person who completed dause of death (Item 23a) (Type, Print) During Test Town MD 2 12ay. 31. Date filed (Month, Day, 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#2perPHYS, G924, 2/9/2012, WS

amend #5 Per FH G924 2/24/2012 JH

Certificate of Death

Reg. No. 2012 for State Registrar 03637 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Day 2012 Year 4 2102 Month Physician/ 6:00 A. Joseph James Witkewics February Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Forest Hill Harford Rock Spring Village 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) Funeral Days **Director** 1 **X**M 2 □ F 1916 New Jersey 95 Oct. 14, ms 23a or 28a-f show must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director Maryland Bel Air 1 Yes 2 X No Harford 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 21014 United States 313 Hemingway Drive death \ 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian 11. Marital Status "natural", or itel Armed Forces?

Yes 2 \(\sum \) No Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 within 72 hours after Specify: White If Yes, Give Year or Dates 1 ☐ Yes XX No Specify: Completed 3₺ Widowed 4 Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) other than Elementary/Secondary (0-12) College (1-4 or 5+) the Supervisor Electrical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) and Mental Fisherships is marked of ပ Constant Witkewics Mary Klimas other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Department of Health ar Important: If item 27 is any injury or other trau 313 Hemingway Drive Bel Air, Maryland 21014 Helene Maloy / Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Evans Funeral Chapel 1 Burial 2 XCremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2/6/2012 Bel Air Forest Hill, Maryland f Funeral/Service Licensee Evans Funeral Chapel & Cremation Service—BelAir 3 Newport Drive Forest Hill, Maryland 21050 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Ph. sician/ disease or condition Medical resulting in death) Due to (or as a con equence of) Examiner Sequentially list conditions, if any, leading to ministrate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last burial-trar and Due to (or as a consequence of): iding physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Dav Year signed by the at Id be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed plnods 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 X No page 2 to the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director, After this certificate to completely filled in by the funeral accompletely filled in 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6XXOther (Specify) Hospice ျ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1XXNatural work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 | 3 | only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) whall February 6, 2012 00026 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Buy Hill Corpor ate Centurinive Abi rigeles 31. Date filed (Month, Day, Y State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Barbara Bolton Wright 5:15 A <u>February</u> 2012 Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner Rockville Montgomery Casey House Year If Under 24 Hrs. 8. Date of Birth (Month, Day, May 27, Birthplace (State or Foreign Country) Social Security Number Age (In yrs. last birthday **Funeral** Hours **Director** 1 □ M 2**X** F Utah 528-40-7994 77 1934 Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10c. City, Town or Location with the Maryland notified at Director 1 Yes 2 No Montgomery Bethesda MD 10f. Zip Code 10e, Street and Number 10g. Citizen of What Country? or Iral", or items 23a of Examiner must be Funeral 5301 Westbard Circle #222 20816 USA permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu once. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 XNo 1 Never Married 2 X Married by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced White Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 4 Staff Secretary Health Research Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, မ Edward Heim Ella Osbourn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5301 Westbard Circle #222 Bethesda, MD 20816 J. Ward Wright/husband 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Final Journey Crematory 02/06/12 Woodbine, MD 22. Name and Address of Facility Ding Home Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 21. Signature of Funeral Service License 23a. Part 1. Enter the deease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Tounge Cancer disease or condition Medical resulting in death) **Examiner** Lung Cancer Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last physician Be Completed by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown for Month Day Year 5 Other (specify) Pregnant at time of death ed by the a detached t 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed b 23e. Did tobacco use contribute to the cause of death? 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed Yes 2 X No 1 ☐ Yes 2 ☐ No certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 XOther (Specify) hospice 1 ☐ Yes 2X No မြ 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 XNatural 5 Pending injury 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation after deatl 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ò determined 24 hours Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hor

To the Fune

completely fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifi 29d. Date signed (Month, Day, Year) 29c. License number R143201 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 06-2011

State

minerastere Mill Rd Rockfilla

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 03639 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death WENNER Physician/ February ERALD 2012^a 5:45 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Hagerstown Washington 950 St Clair Street 9. Birthplace (State or Foreign 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** Days Dec 17, ^{Year)} 1943 Maryland Director 213-42-2135 1 X M 2 □ F 68 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** notified 28a-f 1 X Yes 2 No MD Washington Hagerstown ō 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? must be r 950 St. Clair Street 21742 USA items 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates. 1965–68 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc ō þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after White 1 ☐ Yes 2X No Specify Specify: "natural" Completed 3 Widowed 4 X Divorced Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working Hygiene. other than ' ent, the Me life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Construction 12 other Carpenter Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Ith and Mental F 27 is marked of traumatic ever ပ William Jennings Wenner Mable Pauline Mongean 19a. Informant's Name/Relationship (Type, Print)
Mary Ellen Nails/Domestic
Partner 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health of item 27 i 950 St. Clair Street Hagerstown, MD 21742 other t 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State of cemetery, crematory or other place) 1 Burial 2X Cremation 3 Removal from State ō Department Important: I any injury or Final Journey Crematory 02/08/12 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service License Ging Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate rval Betweer Oal t and Dath Immediate Cause (Final 1-a, lu Ph_{sician/} disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine use as the burial-tra resulting in death) Last the attending physician Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) in the past 12 months? Month Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performe 1 Yes Yes or Attending Physician: 25. Was case referred to medical filled in by the funeral director, 26. Place of Death (Check only one) Certificate: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After 1 Anatural 5 \square Pending 1 Yes 2 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined the Hospital Medical 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of cortifier 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State Registrar

		For	Please ⁻	Type or Pr State of N		d / Depa	artment	of H	ealth		-			ble.	
Physi	cian/	State Registrar 1. Decedent's Name (Fine MATILDA F.				Cer	tificate	of D	eath		2. Date of De Month FEB.	Reg. No ath		12 12	3. Time of Death 12:40AM
Acres -	niner					4b. City, Town, or Location of Death TIMONIUM						4c. County of Death BALTIMORE			
Funer Direct	or	5. Social Security Number 216-20-1173 Usual Residence of Decedent 6. Sex 1 □ M X X F 84				st birthday) Yrs.	If Under 1 Months				V Year) Country		olace (State or Foreign MD .		
ore, Maryland 21215-0036 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "ratural", or items 23a or 28a-1 show other traumatic event, the Medical Examiner must be notified at	Funeral Director	Maryland Baltimore 10c. City, Tov			, Town or Lo	Baltimore County						/		0d. Inside City Limits 1 Yes 2 No	
with the s 23a or	eral	10e. Street and Number 4506 Raspe	4506 Raspe Avenue			10f. Zip Code 21206							itizen of W U SA	hat Coun	try?
036 s after death ral", or items Examiner m	ed by Fun	11. Marital Status 1 Never Married	11. Marital Status 1 Never Married 2 Married 3 X Widowed 4 Divorced 12. Was Arme 1 If Yes Year				Was Decedent of Hispanic Origin? (Specify Yes If Yes, specify Cuban, Mexican, Puerto Rican, et 1 ☐ Yes 2 X No Specify:				cify Yes or No- Rican, etc.)	No- 14. Race - Ameri Black, White, Specify: Whit			etc.
Baltimore, Maryland 21215-0036 Demrit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Moortant if item 27 is marked other than "natural", or items 23a or 28a-f sho my njuly or other traumatic event, the Medical Examiner must be notified at	Completed	(Specify of Elementary/Secondar 12 yrs.		grade completed) (Gir College (1-4 or 5+)			edent's Usual Occupation e kind of work done during most of work DO NOT use retired) memaker			st of workin	king		o. Kind of Business/Industry omemaking-Own Hom		
and 2	To Be	17. Father's Name (First, Bronislaw		18. Mother's Name					(First, Middle, Maiden Sumame)						
Maryl: should the and Me		19a. Informant's Name/F	Relationship (Typ	e, Print)					nd Numb	er or Rural	Route Numbe	er, City o			Code) .1 ,Md.21128
		Louise Kra 20a. Method of Dispositi XXXXBurial 2 Cra 4 Donation 5	emation 3 🗆 F			lace of Dispo emetery, cren	sition (Name natory or oth	of er place	9)		ate	20c. l	ocation - timor	City or To	wn, State
Baltimo permit. Page Department of Important: If any injury or	ouce.	4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Lassahn Funeral Service Licensee 7401 Belair Rd. Baltimore,									ıner	neral Home			
Physicia Medic Examin	al	23a. Part 1. Enter the di shock, or heart fail Immediate Cause (Final disease or condition resulting in death)	sease, or compli	cations that cause cause on each li	ne.	CARDIA			, such as	s cardiac or	r respiratory ar	rest,			Approximate Interval Between Onset and Death
executed an and irial-transit	Examiner	Sequentially list condition if any, leading to immediate the case of the case	iate	Due to (or a	s a consequ s a consequ										
, P.O. Box 68760 ss that the death certificate be greed by the attending physici be detached for use as the bu	Physician/Medical	IF FEMALE: 23b. Was decedent preg in the past 12 mont 1 ☐ Yes 2 🗶 No 9 ☐ Unknown	ns?	3c. If yes, outcom 1 Live Birth 4 Pregnant 9 Unknowr	n 2 ☐ Feta at time of d	Ideath 3	Ectopic pr Other (spe		/				23d. Date Mor	e of delive	ery Day Y ear
ords, P.O. v requires that the been signed by the should be detach	ğ	Part II. Other significant	conditions cor	tributing to death	but not resi	ulting in the u	inderlying ca	use give	en in Part	t f.	23e. Did t		. /		ne cause of death?
fital Records, sician: The law requires retrificate has been significate, page 2 should b	Completed										24a. Was auto perfo	psy ormed?	p	/ere autor rior to cor eath?	osy findings available mpletion of cause of
of Vital ng Physician: ter this certific neral director,	Be	25. Was case referred to examiner? 1 Yes 2 X No	_	ospital:	ationt 2 🗆	ER/Outpatier	* 3 \(\sum_{DO}	Other		ath (Check		donas	c V i Otho	(Cacaibi	HOSPICE
of ng Phy fter thi	icate: To	27. Manner of Death	Pending Investigation	28a. Date of in (Month, D	jury	28b. Time of injury		c. Injury work?	at	2	ne 5 ∟ Resi 28d. Describe I				HOSPICE
Division all or Attendin's after death.	Certificate:	3 Suicide 6 4 Homicide	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)							Route Number,					
Division To the Hospital or Attendi within 24 hours after death To the Funeral Director: A completely filled in by the fi	Medical	(Check 2 🗆 N	ledical Examin	cian: To the best of the basis of Practitioner: To	examination	and/or invest	tigation, in m	y opinior	n, death c	occurred at	the time, date a	and plac	e, and due	to the cau	use(s) and manner stated
To the vithin To the compl	Σ	29b. Signature and title of		unp	and Desi Oi II	, kilowiedge		License		92	oo, and due to		ate signed		
		30. Name and address of JACKIE JOI		mpleted cause of P 2300				<u>ゲー</u> D.	TIM	MITNO	, MD 21	093			
	tate	31. Date filed (Mantin De	1017 /	32. Regis	ur's Siguet	well									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Cecilia Catalina Cuzmar Alegria January 2012 5:12 P м 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Frederick Frederick 1772 Harvest Drive If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 8. Date of Birth 7. Age (In yrs. last birthday) Hours (Month, Day, Yea Jan. 7, 1 577-98-4048 57 Chile 1 - M 2 F 1955 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State Silver Spring Maryland Montgomery 1 Yes 2 XNo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20906 U.S.A. 14211 Pear Tree Lane, Apt. 4 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married Yes 2 X No If Yes, Give Year or Dates 1 x Yes 2 □ No Specify: Chilean Hispanic Specify: 3 Widowed 4 X Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Hair Salon Technician 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Andrea Cuzmar Alegria Cuzmar Nallib 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State Zip Code) 1772 Harvest Drive, Frederick, MD 21702 19a. Informant's Name/Relationship (Type, Print) Carla Moran, Niece 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date cemetery, crematory or other place)
Gate of Heaven 1 XX Burial 2 Cremation 3 Removal from State Silver Spring, MD Jan 30, 2012 4 ☐ Donation 5 ☐ Other (Specify) of Funeral Service Reeney and Bastord PA Funeral Home M00706 106 East Church St., Frederick, MD 21701 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between
Onset and Death
Four Weeks Immediate Cause (Final Metastatic Pancreatic Cancer disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter underlying Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Fctopic pregnancy in the past 12 months?
1 ☐ Yes 2 🕱 No Day 5 Other (specify) Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?

Medical Examiner burial-tran physician the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the use as attending | signed by the ar ate has page 2 s within 24 hours after death.

To the Funeral Director: A completely filled in by the fi

Physician/

Medical

Director

Funeral

þ

Completed

Be

ပ္

Physician/Medical Exam

ğ

Completed

Be 2

Medical Certificate:

29b. Signature and title of certifier

Examiner

Funeral

Director

28a-f shov

9 ms 23a or must be n

ural", or items?

Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene.
sant. If item 27 is marked other than "natural", or items uny or other traumatic event, the Medicial Examiner muny or other traumatic event, the Medicial Examiner muny or other traumatic event,

Department of H Important: If ite any injury or oth

Physician/

Baltimore, Maryland 21215-0036

with

notified

				1 ☐ Yes 2 [X No 3 Probably 4 Unknown			
				24a. Was an autopsy performed? 1 □ Yes 2 ▼ No	24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No			
25. Was case referred to medical			26. Place of Death (Che	eck only one)				
examiner? 1 Pes 2 K No	Hospital: 1 □ Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 □ Nursing Home 5 □ Residence 6 X Other (Specify)							
27. Manner of Death 1 ↑ Natural 5 Pending 2 ↑ Accident Investigation		28b. Time of injury	28c. Injury at work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury	Homo			
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	286 Place of Injuny - At b.		28f. Location (Street and City or Town, State)	8f. Location (Street and Number or Rural Route Number, City or Town, State)				
(Check 2 Medical Exam	sician: To the best of my know iner: On the basis of examinations, Practitioner: To the best of	n and/or investigation, i	n my opinion, death occurred	at the time, date and place,	and due to the cause(s) and manner stated.			

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

501 West Seventh Street, Frederick, Maryland 21701-4507 Elhamy D. Eskander, M.D.,

29c. License number

D48184

29d. Date signed (Month, Day, Year)

January 25, 2012

State Registrar 31. Date filed (Month, Day, Year) 32. Registrar's Signature JAN 2 5

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 18, 2012 EDWARD ARRINGTON January 3:07 P Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 715 Wyngate Drive Frederick Frederick Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** Months Days Hours Min 1 X M 2 □ F **Director** 212-78-2148 Yrs 42 Nov. 22, 1969 Maryland Usual Residence of Decede show 10a. State 10b. County 10c. City, Town or Location aţ 10d. Inside City Limits Director notified 28a-f 1 X Yes 2 No Maryland Frederick Frederick ŏ 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a or ner must be r Funeral 715 Wyngate Drive 21701 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Examiner Armed Forces? 1 Yes 2 No Black, White, etc. ŏ ģ 1 Never Married 2 X Married and 2 should be filed within 72 hours after 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: White "natural" Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) L.C.S.W. Health Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ith and Mental H 27 is marked of traumatic ever မ Kay Sook Synn Edward Arrington 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t: If item 27 is P.O. Box 724, Deltaville, Virginia Edward Arrington / Father 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) Department or Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) Mount Olivet Cemetery 01/23/12 Frederick, Maryland 22. Name and Address of Facility Robert E. Dailey & 1210 North Market Signature of Funeral Service Lice & Son Funeral Homes, P.A. St., Frederick, Maryland & 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Ulsease or Injury Due to (or as a consequence of) Exam and the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last ed by the attending physician detached for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 Yes 2 No 9 Unknown 5 Other (specify) 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by been signe should be 1 ☐ Yes 2XNo 3 ☐ Probably 4 ☐ Unknown CS5100 Be မှ Certificate:

requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 After this certificate has funeral director, page 2 : Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica etely filled in by the funeral director, I To the Hosp within 24 hou To the Funer completely fi

death

Maryland 21215-0036

Baltimore,

		autopsy performed? 1 Yes 2 No 1 Yes 2 No								
25. Was case referred to medical	26. Place of Death (Check only one)									
examiner? 1 Yes 2 No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)									
27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	on Wannery 18 2012 Va Kabwa Light Yes 2 No	8d. Describe how injury occurred self with Victim hanged self with electrical cord								
3 Suicide 6 ☐ Could not 4 ☐ Homicide determined	DE .	28f. Location (Street and Number or Bural Route Number City or Town, State) 715 Wyngate Dork								
29a. Certifier 1 Certifying Ph	ysician: To the best of my knowledge, death occurred at the time, date and place, and	d due to the cause(s) and manner as stated.								

Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifi 23a) (Type, Print) 3

State Registrar

DHMH 17 Rev 06-2011

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedent's Name (First Middle, Last) 2. Date of Death Physician/ Month vetta Medical 4a. Facility Name (if not institution, give street and number) County of Death Examiner 4b. City, Town, or Location of Death Prince Regional Hospita George -dure Social Security Number 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) . Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs. **Funeral** Days 1 M 2 XF 88 Months Hours Min. Director 407-26-872 04/30/1923 Ohio Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits at Completed by Funeral Director ral", or items 23a or 28a-f s Examiner must be notified MD Prince George's Laurel 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7208 Winterfield Terrace 20707 USA and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces Black White etc. 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No 3 Widowed 4 Divorced Specify: Black If Yes, Give Year or Dates event, the Medical 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 8th Meat Wrapper Safeway Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ John Payne Mozelle Crenshaw 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a tem 27 i Doreena Thomas/Daughter 6910 Ingraham Street Riverdale, MD 20737 or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ott 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Harmony Memorial Park 02/01/2012 Landover, MD 21. Signature of Funeral Service Licensee 22. Name and Address of FacilityMarshall-March Funeral Home 4308 Suitland Road Suitland, MD 20746 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of). Cause (Disease or iinjury that initiated events resulting in death) Last as the burial-tran and Due to (or as a consequence of) attending physician for use as the buria Physician/Medical the Hospital or Attending Physician; The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: asn 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year 5 Other (specify) ed by the a detached f 9 Unknown ate has been signed by page 2 should be detacl Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? after death.

Director: After this certificate I 2 No Yes completed filled in by the funeral director, To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1
Yes 28b. Time of 28d. Describe how injury occurred Certificate: Natural 5 Pending Investigation 6 Could not be Accident Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 24 hours a Medical Effertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certified D54223 January Laurel Regional Hospital, Emergency 00 Van Dusen Rd. Laurel, MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7300 Van State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #1Per PHY G924 2/15/2012 JH State of Maryland / Department of Health and Mental Hygiene 20 12 1 - State Registra Certificate of Death Rea. No. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Februar 9 2, 2012 6:10 A M Magdel P. Boone Madgel P. Boone Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Tranquillity at Fredericktowne Frederick If Under 1 Year If Under 24 Hrs Months Davs Hours Min. Social Security Number . Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** May 22,1917 Director 577-01-7763 1 🗆 M 2 🗶 F 94 Ohio Usual Residence of Decedent or 28a-f show 10a. State 10c. City, Town or Location the Maryland at 10d. Inside City Limits Director notified MD Frederick Frederick 1 ☐ Yes 2 🛱 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be Funeral with 23a 5975 Grove Hill Road 21703 United States items death 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Examiner Armed Forces Black, White, etc. þ ö 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after Yes 2X No 3altimore, Maryland 21215-0036 1 Yes 2 No Specify. If Yes, Give 'natural", Specify: White 3 ☒ Widowed 4 ☐ Divorced Completed Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) traumatic event, the Accounts Receivable Bio Tech Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, and Mental I ၉ Ambrose Danford Della Viola Ankrim 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Turner (Son) 27 5975 Grove Hill Rd., Frederick. MD 21703 item 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Important: If it any injury or o 1 XBurial 2 Cremation 3 Removal from State Washington Cem 2/7/2012 Adelphi, MD 4 Donation 5 Other (Specify) Geo. 21. Signature of Funeral Service Licensee Keeney & Basford P.A. Funeral Home 106 E. Church St., Frederick, MD 2 MO1612 MD 21701 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line nterval Retween Onset and Death Immediate Cause (Final Ph_sician/ Dementio disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, Examiner Directo (or an a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events burial-transit resulting in death) Last Due to (or as a consequence of) nding physician Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death use 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) atten jo in the past 12 months?

1 Yes 2 No ☐ Live Birth ∠ ☐ 1 et al 300... ☐ Pregnant at time of death ☐ Unknown Day Month Year signed by the a 1 Yes 2 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Completed 1 Yes 2 No 3 Probably 4 Unknown should been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy perform To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate to Yes 2 1 Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation filled in by the 6 Could not be Suicide 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 12/2012 R093550 20 M 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1126 opel Court Hagaretown Mancefan 31. Date filed (Month, Day, Year) FEB 0 9 2012 32. Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death codent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Bowman Physician/ 55PM Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner NMS (tow Nushu 9. Birthplace (State or Foreign If Under If Under 8. Date of Birth Funeral 7. Age (In yrs. last birthday) Months Min May 129, 1 🗆 M 2 📈 MaryTand 1949 62 214-48-4197 Director Usual Residence of Deceden 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic and any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10c. City, Town or Location 10d. tnside City Limits 10a. State Director 1 Xyes 2 🗌 No MD Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11 South Walnut Street, # 206 21740 12. Was Decedent Ever in U.S. Armed Forces?

1 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: Completed 3 ₩Widowed 4 □ Divorced Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Bookkeeper Accounting Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ John D. Sarco Hilda H. Butterbaugh 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cassie Minnich / Daughter 18123 Manor CHurch Road, Boonsboro, MD 21713 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Smithsburg Crematory 2/3/2012 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg, Maryland Signature 22. Name and Address of Facility Rest Haven Funeral Chapel Funeral Service 1601 Pennsylvania Ave., Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Prysician/ Mar disease or condition resulting in death) Medical Due to (or as a consequen w of) Examiner Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or linjury Due to for as a consequence of attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Year Pregnant at time of death 2 No certificate has been signed by the rector, page 2 should be detached Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>ک</u> 2 No 3 Probably 4 Unknown 1 Yes Completed 2 monary Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death' 1 Yes 2 No director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 V No ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred After t 5 Pending s after death.

I Director, Aff d in by the ful 1 Yes 2 🗌 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours after
To the Funeral Director of the F Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check SC Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated the only one 29b. Signature and title of certifier မ

Registrar
DHMH 17 Rev 7/2009

State

Name and address of person who completed c

400

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

JAN

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

of Vital

Division

32. Registrar's Signature

DHMH 17 Rev 06-2011

State Registrar

Box 68760

P.O.

	1	12 Allegany Co. = State Registrar	State of M	aryland / Depa Cea	artment of I rtificate of L			jiene leg. No. 2 N	2 0361
Physicia Medic	n/ al	Decedent's Name (First, Middle, Robert	Eugene	Brinkm	_		2. Date of Dear Month	25 20%	3. Time of Death 2 0005
Examin	er '	4a. Facility Name (if not institution, s	give street and number)		Cumb			4c. County of Dea	
Funeral Director		5. Social Security Number 217-18-4406 Usual Residence of Decedent	5. Sex 7. Ag 1 X M 2 □ F	e (In yrs. last birthday) 89 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day NOV 2	9, 1922 9. B	irthplace (State or Fore ountry) MD
faryland Ba-f show tified at	ector	10a. State 10b. County	ieral	10c. City, Town or Lo Rid	geley				10d. Inside City Lim 1 ☐ Yes 2 🂢
with the Maryland 23a or 28a-f sho ust be notified at	Funeral Director	10e. Street and Number Rt. 1 Box 487E	2		10f. Zip Code	26753		10g. Citizen of What C	-
1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	þ	11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorced	12. Was Decedent I Armed Forces?	No	Was Decedent of H If Yes, specify Cuba 1 Yes 2 No	lispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No- pecify Yes or No- pecify Yes or No-	14. Race - Am Black, Whi	
iin 72 hours ie. han "natura e Medical E	Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12)	's Education	16a. Dece (Give life. D	dent's Usual Occup kind of work done o O NOT use retired)	during most of wor Nucl	ear	16b. Kind of Business	s/Industry
be filed with ental Hygien ked other ti c event, the	a) F	12 17. Father's Name (First, Middle, La Wilbert E. B		<u>Nuc</u>	elar Physi	18. Mother's Nar	icist ne (First, Middle, M Estella Ho		ent
2 should th and Me 27 is mar traumati		19a. Informant's Name/Relationshi Julie A. Rice			ng Address (Street 76 Oak Gr			City or Town, State, 2	Zip Code) WV 25427
age 1 and ent of Heal nt: If item 3 y or other		20a. Method of Disposition 1 ☐ Burial 2 ☐ Xremation 4 ☐ Donation 5 ☐ Other (Sc	3 ☐ Removal from State	20b. Place of Dispo		ce)	Date 1/25/2012	20c. Location - City o	
permit. Page 1 Department of Important: If i any injury or once.		21. Algnatur of Funeral Service Lic			2. Name and Addre	es of Facility elli Funeral F	Home, PA Je: Cumberla	and, MD 21502	
ate be executed hysician and the burial-transit the burial-transit	dical Examiner	shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. AS PL Due to (or as b. Due to (or as	a consequence of): a consequence of): a consequence of):		umon yspha			Interval Between Onset and Death ONE Now
res that the death certificate I signed by the attending phys d be detached for use as the		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No g ☐ Unknown	23c. If yes, outcome 1 Live Birth 4 Pregnant a	2 Fetal death 3	Ectopic pregnand Other (specify)	су		23d. Date of d Month	lelivery Day Year
requires that the been signed by the should be detach	by	Part II. Other significant condition	ns contributing to death t	out not resulting in the	underlying cause gi	ven in Part I.	23e. Did to	bacco use contribute	to the cause of death?
nysician: The law require nis certificate has been si I director, page 2 should I	Completed						24a. Was a autop perfor	sy prior to med? death?	autopsy findings availa completion of cause es 2 \(\square\) No
sician: s certific director,		25. Was case referred to medical examiner?	Hospital:	ient 2 🗆 ER/Outpatie	Oth	lace of Death (Che		ence 6 Other (Spe	aciful
Attending Physician: rr death. ector: After this certific by the funeral director.	Certificate: T	27. Magner of Death Natural 5 Pending Pen	28a. Date of inju (Month, Da ation	ıry 28b. Time o	f 28c. Injur	ry at		ow injury occurred	Jony/_
To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di		3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determin	ned 286. Place of Inj building, et				City or Town		
he Hospi in 24 hou he Funer pletely fil	Medical	(Check 2 Medical Ex	Physician: To the best of caminer: On the basis of c Nurse Practitioner. To th	examination and/or inves	stigation, in my opini	on, death occurred	at the time, date ar	nd place, and due to the	e cause(s) and manner s
To the within		29b. Signature and title of certifier	n Fan	m MD	29c. Licens			29d. Date signed (Mor	
\-		30. Name and address of person w		death (Item 23a) (Type,		Rd (embert	and me	y 25,20 3 21502
	e	31. Date filed (Month, Day, Year)	32 Renistr	ar's Signature	Mark.				J. 0-54

Registrar DHMH 17 Rev 7/2009

State

Box 68760

P.O.

Division of Vital

ST

Grantsville MD 21536

124

BISSELL

DR ROBIN

Miller

37. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2012 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** Dorothy Louise Buchanan 26, 2012 08:45A January /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington

9. Birthplace (State or Foreign Country) Homewood Of Williamsport Williamsport
If Under 1 Year I If Under 24 Hrs. 5. Social Security Number . Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 □ M 2 🗓 F 89 215-18-1750 6/15/1922 Director Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modical Examiner must be notified at 1 ☐ Yes 2 No Directo Maryland | Washington Maugansville 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 14209 Maugansville Road 21767 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 □Yes ※XXNo 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Tes 22 If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2X No Specify: White Š 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) than Elementary/Secondary (0-12) College (1-4or 5+) Beautician Beauty snould be file the and Mental Hv. 7 Is mark 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 Is marked any injury or other traumatic evonce. Florence Viola Lowery 2 Harvey Keener Martin 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Darrel H. Buchanan/ Husband 14209 Maugansville Rd. Maugansville, Maryland 21767 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 █ Burial 2 ☐ Cremation 3 ☐ Removal from State Rest Haven Cemetery 01/30/2012 | Hagerstown Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rest Haven Funeral Chapel S. Mark 23a. Part1. Enter the disease, or complications at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one could on each line. |1601 Pennsylvania Ave. Hagerstown Maryland 21742 Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 1-2 dags Acute 46 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Unious or injury that initiated events Due to (or as a consequence of): Examiner law requires that the death certificate be executed use as the burial-tran resulting in death) Last Due to (or as a consequence of): physician 68760 Physician/Medical Box IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 □Yes 2 □ No. Ö 9 Unknown is been signed by the should be detached σ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, φ iteris schanding alis Vanan 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' certificate 1 ☐ Yes 2 X No 1 ☐Yes 2 ☐No Division of Vital Hospital or Attending Physician: funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Narsing Home 5 Residence 6 Other (Specify) 1 Yes 2 1 No Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation neral Director: A 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide determined 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number at no D(8019 JKN 41262012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) auce of MACERSTOWN MO 21740 JW- Z DATTE NO 340 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

Barto

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Lisa Marie BREEDEN 6:19a. M 30, 2012 January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death **Washington Examiner** 285 Frederick Street Hagerstown Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 188-54-4100 Months Davs Hours Min FeB. 20 Year) 1963 48 Pennsylvania Yrs **Director** Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director Spring Church PA Armstrong 28a-f 1 Yes 2 K No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or important: If item 27 is marked other than "natural", or items 26a or injury or other traumatic event, the Medical Examiner must be a one. 15686 Funeral 1 Wood Lane P.O. Box 134 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14 Bace - American Indian. Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 M Married Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify 3 Divorced 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) accountant secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Lorraine Deer James Wood 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kenneth Platt - son 21740 285 Frederick Street, Hagerstown, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Page 1 1 🗆 Burial 2 🗆 Cremation 3 🖾 Removal from State Feb. 6,2012 Penn Hills, PA 4 ☐ Donation 5 ☐ Other (Specify) Mt. Hope cemetery Signature of uneral Service Licenses 22. Name and Address of Facility Minnich Funeral Home 415 East Wilson Blvd., Hagerstown, Maryland 21740 23a, Part 1, Enter the disease, or complications that caused the death. Do not enter the mode of dving, such as cardiac or respiratory arrest. Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ CIRR HOSIS Medical resulting in death) Due to (or as a consequence of) Examiner CLEROSINI Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine BILIARY nding physician and use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical death certificate be P.O. Box 68760 use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy atter in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death Yes been signed by the a should be detached t g Unknown Unknown Hospital or Attending Physician: The law requires that the 24 hours after death.
 Funeral Director: After this certificate has been signed by th Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ¥ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed Yes 2 1 Yes funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Other: 4 \(\sum \) Nursing Home 5 \(\sum \) Residence 6 \(\begin{align*} \text{Other (Specify)} \) Hospital: 2 No 1 🗌 Yes ပ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation filled in by the Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State)

To the within 2 To the F

State

Registrar

Medical

completed

29a. Certifier

(Check

only one 29b. Signature a

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

STREET #306 HAGERSTOWN MS 21740

29d. Date signed (Month. Day, Year)

JANHARY

31. Date filed (Month

💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

			State of Mary				Mental Hyg	iene		
			State Registrar 1. Decedent's Name (First, Middle, Last)	Cer	tificate of D	eath	1	eg. No. 2	112	03652
	Physicia Medic		Alfred J. Bacon				2. Date of Deat 01-16-2		Year	3. Time of Death 230 P M
	Examin		4a. Facility Name (if not institution, give street and number)		4b. City, Town, or			4c. County o		
	′ 		#1 Saint James Ct 5. Social Security Number 6. Sex 7. Age (In	t t-t-t-t	East of If Under 1 Year	n If Under 24 Hrs	Lant (Div	Tal		
	Funeral Director		. 77	yrs. last birthday) 34 Yrs.	Months Days	Hours Min.			9. Birthp Count	lace (State or Foreign PA
	d t t		Usual Residence of Decedent 10a, State 10b. County 10	Oit Town and a					1	
	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at	Director	MD Talbot	c. City, Town or Loc Easton	cation				110	0d. Inside City Limits 1 Yes 2 No
	or 28 e noti		10e. Street and Number		10f. Zip Code		l i	0g. Citizen of W	hat Count	
	with s 23a ust b	Funeral	#1 Saint James Ct		2160)1		USA		
	death item ner m		11. Marital Status 12. Was Decedent Ever Amped Forces?	n U.S. 13. V	Was Decedent of His f Yes, specify Cubar	spanic Origin? (S n, Mexican, Puer	pecify Yes or No- o Rican, etc.)	14, Race	- America , White, e	,
936	s after al", o	d by	1 ☐ Never Married 2 ☒ Married 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates.	1	☐ Yes 2X No	Specify:		Specify:		
Š Ž	hours hatur dical	olete	15. Decedent's Education (Specify only highest grade completed)		dent's Usual Occupa		rking	16b. Kind of Bus	iness Ind	ustry
2	hin 72 ne. than "	Completed	Elementary/Seconday (0-12) College (1-4 or 5+)	life. DO	kind of work done do O NOT use retired)	uning most or wo	rking	N		
р О	filed wit tal Hygie d other event, th	Be	17. Father's Name (First, Middle, Last)	Print	.eı	18 Mother's Na	me (First, Middle, N	Newspap	<u>e1</u>	
/lan	d be fil Aental Irked tic ev	욘	Alfred J. Bacon, Sr.				beth Hind			
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatht and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationship (Type, Print)	1	ng Address (Street a					ode)
e,	and 2 s Health tem 27 ther tra		Frances M. Bacon (Wife) 20a. Method of Disposition	#1 Sa	int James	Court		MD 2160 20c. Location - 0		un Stata
nor	Page 1 ment of ant: If it ury or o		1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	cemetery, cren Chesapeak	natory or other place te Cremati iter	on 1_1	8-2012	Stevens	-	
alti	permit. Page Department (Important: II any injury or		21. Signature of Funeral Service Licensee		Name and Address LILOWS, He					
<u>m</u>	8 8 m 8 8		JOHN R. MERCERS	<u> </u>	<u>00 S. Harr</u>	<u>cison St</u>	Easton	MD 2160	1	ome, r.A.
			23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause or each line.	death. Do not ente	_ /	1 .		st,		Approximate Interval Between
	Medical		Immediate Cause (Final disease or condition resulting in death)	nsequence of);	deart	failu	re		/-	S years
مسرده	Examiner			sequence on.	L	£				0
	p #	Examiner	Esque tielly list on ultione, if any, leading to immediate cause. Enter Underlying	sequence of):			,			
	ecute and Il-trans	Exan	Cause (Disease or iinjury that initiated events c. Due to (or as a cor resulting in death) Last	sequence of):					\dashv	
00	ite be executed hysician and he burial-transit	dical	d							
6876	tificate ng ph)	Med	IF FEMALE:							
Box 6	ath cer attendi for use	ian/	23b. Was decedent pregnant in the past 12 months?	Fetal death 3	Ectopic pregnancy Other (specify)	′		23d. Date Mont		ry Day Year
<u>.</u>	he des y the s	Physician/Me	1 Yes 2 No 4 Pregnant at time 9 Unknown	or death 5 L	Other (specify)					,
P.O.	s that t gned b	by P	Part II. Other significant conditions contributing to death but no	t resulting in the u	nderlying cause give	en in Part I.				e cause of death?
rds,	equires sen siç rould b						1 □ Y€	es 2 1 No 3	B 🗌 Prob	ably 4 🗆 Unknown
Records,	has by ge 2 sh	Completed					24a, Was ar autops	y pr		sy findings available npletion of cause of
m m	sician: The la certificate ha irector, page 2		25. Was case referred to medical		26 Pla	ce of Death (Che	perform	No 1	Yes	2 4 N o
Vita	ysicia is cert direct	To Be	examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient	2 ER/Outpatien	Othor	r.	fome 5 Reside	nce 6 🗆 Other	(Specify)	
o	ing Ph ifter th ineral		27. Manner of Death 1 Natural 5 Pending 28a. Date of injury (Month, Day, Yea	28b. Time of		at	28d. Describe ho			
sion	uttendi death stor: A y the fi	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be	At home farm stre		∕es 2 □ No	28f. Location (Str	and Number	or Pumili	Poute Number
Division of Vital	al or A s after I Direct I in by		4 ☐ Homicide determined building, etc. (Sp.	ecify)	set, factory, office		City or Town,		Or Hurai i	noute Number,
_	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier 1 Certifying Physician: To the best of my k (Check 2 Medical Examiner: On the basis of exami	nowledge, death c	occured at the time,	date and place, a	and due to the caus at the time, date and	e(s) and manner	as stated	I. se(s) and manner stated.
	o the l	Me	only one) 3 Certifying Nurse Practioner: To the best 29b. Signature and title of certifier			time, date and pl	ace, and due to the		ner as sta	ted.
	F 5 F 0		Yorafa Welm O. K.	(1)	DOD	53600		01/18	3/2	012
			30. Name and address of person who completed cause it death	(Item 23a) (Type, P	rint)		^	- /	/	
13	2+VA		31. Date filed (Month, Day, Year) 9 2012 32. Jegistrar's S	D 50	& Idle	wild	tre Ec	iston	m	D 31601
	Stat Registra	e ar	31. Date filed (Month, Day, Year) 9 2012 32. Jegistrar's S	ignatury.	OV.					

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deat Physician/ Edward Babatunde Baker 2012 January 10:30 A.M Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Montgomery Holy Cross Hospital Silver Spring If Under If Under 24 Hrs 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) 1 Year 8. Date of Birth **Funeral** Days Cowest Africa Months Hours (Month, Day, Year) 579-76-9205 **Director** 66 Yrs March 27,1945 Sierra Leone Usual Residence of Decedent 28a-f show 10c. City, Town or Location 10d. Inside City Limits must be notified at Director 1 X Yes 2 No Hyattsville Maryland Prince Georges ō 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 23a Funeral 7100 - 24th Avenue 20783 United States items Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc ō 1 Never Married 2 Married ģ Yes, Give 2 **X** No 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. **Black** Specify: "natural", 3 Widowed 4 X Divorced Completed Year or Dates the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. other than " Elementary/Secondary (0-12) College (1-4 or 5+) 4 years Rehabilitation Counselor **Holistic Company** traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) marked Mental ည Suzzane Williams James Baker Ayo 1 and 2 should by Health and Meitem 27 is mark 19a. Informant's Name/Relationship (Type, Print) (Brother) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6943 Nashville Road; Lanham, Maryland 20706 George Samuel Nicol other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Page 1 Department of H Important; If ite any injury or ot once. Feb. 2, 2012 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Adelphi, Maryland George Washington Cemetery 22. Name and Address of Facility R. N. Horton Company Morticians, 21. Sonature of Funeral Se Inc.;600 Kennedy Street, N.W.; Washington, D.C. 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ Sepsis disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami Cause (Disease or injury that initiated events Immunosuppressed State the burial-tra Due to (or as a consequence of) resulting in death) Last Physician/Medical Metastatic Colon Carcinoma Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Por Month Day Year 5 Other (specify) Pregnant at time of death signed by the at d be detached for 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 this certificate has autopsy nerfor ☐ Yes 2☐ No 2 **X** No Yes To the Hospital or Attending Physician; within 24 hours after death.

To the Funeral Director. After this certific; completely filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 X No Other: 은 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury 1 X Natural 5 Pending 1 Yes 2 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 1 🚨 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

State

Registrar DHMH 17 Rev 06-2011 and title of certifie

Veerappan Alagarsamy,

29b. Signature

ellappan

32. Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

D0067279

M.D.;1500 Forest Glen Road; Silver Spring, Maryland 20910

29d. Date signed (Month, Day, Year)

January 22, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death KENDRICK BERNARD BLANDING Physician/ JANUARY 23. 201 5:13P Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** NATIONAL INSTITUTES OF HEALTH BETHESDA MONTGOMERY Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min Month Bay, Year 92 249-89-1467 19 SC **Director** Usual Residence of Decedent 10a. State 10h. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Ħ Director r 28a-f sl notified SC SUMTER SUMTER 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a o Funeral 1070 HABITAT DRIVE 29153 IIS Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 11. Marital Status 14, Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: BLACK If Yes, Give Year or Dates Specify Completed 3 Divorced 4 Divorced the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72
Department of Health and Mental Hygiene.
Important; If item 27 is marked other than "I any injury or other traumatic event, the Medone." Elementary/Seconday (0-12) College (1-4 or 5+) STUDENT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည KENNETH L. McFADDEN TERESA BLANDING 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) TERESA BLANDING/MOTHER 1070 HABITAT DRIVE, SUMTER, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
MT OLIVET MEMORIAL
GARDENS 1 XBurial 2 Cremation 3 Removal from State 1-30-2012 SUMTER, SC 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Paneral Service Ligensee MOI & 33 POPE FUNERAL HOMES P.A. 22. Name and Address of Facility 5538 MARLBORO PIKE, FORESTVILLE, MD 20747 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ acute respiratory disease or condition resulting in death) Medical Examiner chronic aranulomatous Sequentially list conditions, Examine Due to (or as a conse un nce of) if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23h Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Pregnant at time of death 9 Unknown page 2 should be detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has Yes 2 No 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 ☑ No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work? 1 \(\text{Yes} \) 2 \(\text{No} \) iniury Natural 5 Pending Accident Investigation after death the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide completed filled in by determined City or Town, State) 24 hours Medical 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 23/2012 D0069443 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

euna

2. Registrar

10 CENTER DRIVE, BETHESDA, MARYLAND 20892

12-00622

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hydiene

Aeris Lashay I	seard	1- For State Ame	end#7per			artment of rtificate of				Re	eg. No.	201	2 0365
Physic Medical Exar		1. Decedent's Nam	e (First, Middle,L Lashay B						2	Date of Dea Month January 2	th Day 2, 2 01 2	Year 2	3. Time of Death 1847 hrs
		4a. Facility Name (14100 Bran	if not institution,		mber)		4b. City, To Laurei	own, or Location			4c. 0	County of Deat ince Georg	
Funera Directo		5. Social Security N	889 1	Sex M 2 XF	7. Age (In yrs. I	ast birthday) 19 _{Yrs}	If Under Months			8. Date of Bir		Forei	rthplace (State or gn NEW YORK
any		Usual Residence of 10a. State	f Decedent 10b. County		10c. City,	, Town or Locat	ion						10d. Inside City Limits
faryland	ito	MD 10e, Street and Nu		George's	Lau	ırel	10f. Zip (Code		I î	Oa. Citize	en of What Cou	1 X Yes 2 No
the Mai	Director	11211 Ba		Terrace			20708				USA		
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int. If item 27 is marked other than "natural", or items 23a or 28a-fithon Market of the Maryland Market of the Maryland State of the Market of the Ma	Funeral	11. Marital Status 1 Never Marri 3 Widowed		A 4 F	2 No	If Y	es, specify	t of Hispanic Ori Cuban, Mexican	n, Puerto R			White, etc.	rican Indian, Black,
nours aft	ed by	15.5	ducation (Specify	only highest grad	e completed)	16a. Deceder	nt's Usual O	occupation (Give	kind of wo			nd of Business	/Industry
036 ithin 72 h ne.	Completed	Elementary/Sec	ondary (0-12)	College (1- 2 years		Stude					None	2	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If them 27 is marked other than interportant the term 27 is marked other than 1 in the 27 is marked other than 1 in the 27 is marked other than 1 in the 27 is marked other than 1 in the 27 is marked other than 1 in the 27 is marked other than 1 in the 27 is marked other than 1 in the 27 in marked other than 1 in the 27 in marked other than 1 in the 27 in marked other than 1 in the 27 in marked other than 1 in the 27 in marked other than 1 in the 27 in marked other than 1 in the 27 in marked other than 1 in the 27 in marked other than 2 in the 27 in marked other t	Be Co	17. Father's Name Michael		ist)					er's Name (F a Beat	First, Middle, P	Maiden Si	urname)	
D 21; should b and Men 7 is mark	To	19a. Informant's Na	me/Retationship	(Type, Print) ison/Moth	er		-	(Street and Nu	mber or Ru	ral Route Nun			
re, M s 1 and 2 f Health f item 2		20a. Method of Dis	position	·	20b.	Place of Dispos crematory or ot		e of cemetery,	1	Date		ocation - City o	
Baltimore, permit. Pages I ar Department of Het Important: If ite	50 6		Other Spec	ify:	Lin	ncoln Mo		a1 Address of Facili				tland,	MD al Home
		Tiveur		edere	Jr.	430	08 Su:	itland 1	Road	Suitla	nd. N	MD 2074	6
Physicia /Medica	1	23a. Part I. Enter the failure. List or Immediate Cause	ly one cause on	mplications that ca each line. a. Gunshot Wo			ne mode of	dying, such as	cardiac or r	espiratory arr	est, snock	k, or neart	Approximate Interval Between Onset and Death
Examine		or condition resulti	ng in death)	Due to (or as a	consequence o	of):							
	niner	Sequentially list co if any, leading to in cause. Enter Under	nmediate erlying Cause	Due to (or as a	consequence o	of):						_	
uted od	Examiner	(Disease or injury events resulting in		Due to (or as a	consequence o	of):							
50, te be executed ysician and	ledical	UNPENDED		AMENDED							Local	5 (()	
OX 6876 eath certificate attending phere	rsician/N	IF FEMALE: 23b. Was decedent past 12 months		1 ✓ Live bi 4 Pregna	ant at time of de	2 Fe	etal death ther (Specia		ic pregnanc	Э у		Date of deliver Month	ry Day Year
that the de	됩	Part II. Other sign	ficant condition			esulting in the u	underlying o	cause given in P	art I.				the cause of death?
Division of Vital Records, P.O. rail or attending Physician: The law requires that the raper death. The all Director After this certificate has been signed by led in the former of director one 2 should be death.	Completed I									24a. Was	an	24b. Were a	utopsy findings available completion of cause of
tal Rec	o Be Con	25. Was case refer	red to medical					6.Place of Death	n (Check on	1 Yes		1 🗸 Y	es 2 No
F Vita Physicia or this cer	To Be	examiner? 1 Yes 27. Manner of Dea	2 No		npatient 2	ER/Outpatient		Other ₄		Home 5		ce 6 Othe	er: Scene
ion of tending Pl eath. or: After	ation: T	1 Natural 2 Accident	5 Pending			FOUND: 1819 hrs		1 Yes 2 ✓	_ ९	ubject sho		y occurred	
Divis spital or At tours after d acral Direct	ledical Certification	3 Suicide 4 ✔ Homicide	6 Could r	ot be 28e. Place	of Injury - At h Multi-Fami		et, factory,	office building, e				#202, Laure	ural Route Number, City
To the Ho within 24 P	Medical	29a. Certifier 1 (Check only one) 2		iclan: To the best ner:On the basis o and manner st	f examination a								
# 18 H 2	¥ ¥	29b. Signature and	1	11 11				O.C.M.E.	r		1	ate signed (Mo	onth, Day, Year)
1 ~		30. Name and add	•	no completed caus	•								
K 5	State	Melissa Bra		Assistant Med			/. Baltim	ore Street, E	Baltimore	e, MD 2122	23		
Reg			7 2012	Burne	gistrar's Signati	alle							

TPlease Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Amend#29dPerPhys.PGC1-27-12 Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death IVA BARNES J'MMh 18 Day 2012 ar Physician/ 9:15PM M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** TAKOMA PARK MONTGOMERY WASHINGTON ADVENTIST HOSPITAL Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 6. Sex **Funeral** Months Days Hours SEPT 16 579 32 0804 89 Director 1 □ M 2 🕱 F NC Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location within 72 hours after death with the Maryland Director WASHINGTON 1 Xyes 2 No DC 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral USA 20002 1105 ABBEY PLACE N.E. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2 No þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: BLACK 1 ☐ Yes Ž ☐ No Specify: If Yes, Give Year or Dates "natural", Completed 3 X Widowed 4 Divorced and Mental Hygiene.

is marked other than "naturenumatic event, the Medical. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) FEDERAL GOVERNMENT College (1-4 or 5+) Elementary/Secondary (0-12) PERSONNEL ASSISTANT traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 ORA WHITE ARTHUR M. RAIFORD 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health a Important: If item 27 is any injury or other trau once. JACQUELINE CATOE/DAUGHTER 1515 ANACOSTIA AVE. NE WASH. DC 20019 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 XBurial 2 Cremation 3 Removal from State WASH. DC 1/27/12 **\$LENWOOD CEMETERY** 4 ☐ Donation 5 ☐ Other (Specify) of Funeral Service Licensee 22. Name and Address of Facility 21. Signarur WATSON FH 3435 14th ST NW WASH. DC 20010 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part 1. Interval Between Onset and Death Immediate Cause (Final Physician/ Dronar disease or condition resulting in death) Medical ue to (or as a consequent Examiner Pars 1101 Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as physician and s the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical or Attending Physician: The law requires that the death certificate be Box 68760 as the k a ending IF FEMALE: uS6 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☑ No Month Day Year Pregnant at time of death the g Unknown 9 Unknown P.O. ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 N Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page certificate 2 🗌 No 1 🗌 Yes Yes Division of Vital funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 1 🗌 Yes 2 🔀 No ျှ 1 Inpatient 2 KER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred eral Director: After filled in by the funer (Month, Day, Year) 1 🗺 Natural 5 Pending 1 Yes 2 No M Investigation hours after death Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) To the Hospital within 24 hours a To the Funeral Completely filled Hospital Medical 😭 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) 2012 29b. Signature 29c. License number iddress of person who completed cause of death (Item 23a) (Type, Print) 7600 Carr Fhinds) AdiMinhi Vive WESTakong State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month Physician/ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death LME CIN If Under 1 Year If Under 24 Hrs. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday)
Yrs. **Funeral** 6. Sex 8. Date of Birth Days Min pth D 1 🗆 M 2 🗸 F 216-14-1433 **Director** Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" any injury or other traumatic event. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Cumberland MD Allegany 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21502 USA 11211 Sunrise Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married þ 1 Yes If Yes, Give 1 ☐ Yes 2 🖁 No Specify: Specify: 3 X Widowed 4 Divorced white Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Celanese Corp laborer Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ည Hazel Liller Matthew Dowling 19a. Informant's Name/Relationship (Type, Print) Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 614 White Avenue Cumberland MD 21502 Barbara Metz daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🗷 Burial 2 🗆 Cremation 3 🗆 Removal from State Hillcrest Memorial Park MD 1/31/2012 Cumberland Donation 5 ☐ Other (Specify) ignature Funeral Service 22. Name ard carpeniff furileral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a Part 1 Immediate Cause (Final Onset and Death Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examin burial-transit Cause (Disease or iinjury that initiated events Der Due to or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death signed by the a d be detached f 2 No Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law 24 hours after death.

Funeral Lirector After this certificate has be autopsy 1 🗌 Yes 2 No Yes Be 25. Was case referred to medica 26. Place of Death (Check only one) Hospital 2 No မ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 24 hours 29a. Certifier Certifying Physician: To the kent of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the "asi," of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Fractioners of the cause (s) and manner stated Certifying Nurse Fractioners of the cause (s) and manner stated Certifying Nurse Fractioners of the cause (s) and manner stated Certifying Nurse Fractioners of the cause (s) and manner stated Certifying Nurse Fractioners of the cause (s) and manner stated Certifying Nurse Fractioners of the cause (s) and manner stated Certifying Nurse Fractioners of the cause (s) and manner stated Certifying Nurse Fractioners of the cause (s) and manner stated Certifying Nurse Fractioners of the cause (s) and manner stated Certifying Nurse (s) and manner stated Certifying Nu Gertifying Nurse Fractioner: 29b. Signature and 29c. License number 29dl Date signed (Month, Day, Year) (Hem Ja) (Type, Frint) of person who completed cause of 21502 30 Name and add 600 Memorial Ave. Ste. 203 Cumberland MD

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 | 2

			For State	State of N	/larylan					Mental Hy	giene	010	00650
			Registrar	0.041		Cer	tificate	of Dea	ath		Reg. No.	112	03658
	Physicia	n/	Decedent's Name (First, Middle, L	,	_					2. Date of De Month	Dav	2012	3. Time of Death
	Medic		4a. Facility Name (if not institution, g	amilton S.		ico, J	T			Januar			11:15 A ^M
	Examin	er	, , , , , , , , , , , , , , , , , , , ,	,			4b. City, 10		cation of Death			ty of Death	
*	Funeral		26400 Haine 5. Social Security Number 6		ge (In yrs. Ia	ast birthday)		Year If	ksburg Under 24 Hrs.	8. Date of Bir	th		place (State or Foreign
	Director		579-30-9534	1 ■ M 2 □ F		Yrs.	Months	Days H	lours Min.	(Month, Da		Coun	
	T OW		Usual Residence of Decedent 10a, State 10b, County		82					Aug. 2	2,1929		ington, DC
	ryland -f sh ied a	cto			10c. City	, Town or Lo						1	0d. Inside City Limits 1 Yes 2 No
	e Ma r 28a notif	Director	Maryland Mont	gomery			10f. Zip C		sburg_		10g. Citizen of	Mark Cours	12-14
	rith th	ra					101. Zip 0		0.71		rog. Citizen o		uyr
	ems r mu	Funeral	11. Marital Status	nes Avenue		3. 13. V	Was Deceder	nt of Hispa	871 anic Origin? (Sp	ecify Yes or No-	14. Ra	USA ice - Americ	an Indian.
9	or it	by F	1 Never Married 2 Marrie	Armed Forces 1 Yes 2 If Yes, Give					/lexican, Puerto	Rican, etc.)		ack, White,	
21215-0036	urs af ural" al Exa		3 Widowed 4 Divorced	Year or Dates.	1930-1	.934	Yes 2	No S	specify:		Specif	y: Wh	ite
5	72 ho n "nat edic	Completed	15. Decedent's (Specify only highest			(Give I	dent's Usual (kind of work (done durin	n ng most of work	ring	16b. Kind of	Business/Ind	dustry
12	ithin of the man	Con	Elementary/Secondary (0-12)	College (1-4 or 4	r 5+)	life. Di	O NOT use re Meat	_ ′	er			Foo	ds
	Hygi Other ent, t	a)	17. Father's Name (First, Middle, Las	<u>.</u>			mode			ne (First, Middle,	Maiden Surnar		
Maryland	ge 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene. If if then 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	T ₀	Hamilton S. Ca	rrico					Mary Ru	th McDa	niel Ca	rrico	
lary	should and N is ma	9	19a. Informant's Name/Relationship	(Type, Print)		19b. Mailin	ng Address (S	Street and	Number or Rur	al Route Numbe	er, City or Town,	State, Zip C	Code)
Σ	and 2 s Health tem 27		Maria Gloria Ca	rrico, Wif	e	2640	0 Hair	nes A	venue,	Clarkst	urg, Ma	rylan	d 20871
ore	e 1 al t of H lf itel or oth		20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3	☐ Removal from Stat		lace of Dispo emetery, cren				Date	20c. Location	- City or To	wn, State
Baltimore,	t. Pag tmen tant: tjury		4 Donation 5 Other (Spe	ecify)		01ive				8,2012			Maryland
Ba	permit. Page 1 Department of Important: If i any injury or once.		21. Signature of Fy et al Service Lice	- Jawer	12h	1 2	6401 b	₹idge	Road	ıs, P.A. Damascı	is MD 2	al Ho 20872	me
			23a. Part 1. Eliter the disease, or co shock, or heart failure. List only	omplications that cause y one cause on each li	ed the death ne.	n. Do not ente	er the mode o	of dying, s	uch as cardiac	or respiratory a	rest,		Approximate Interval Between
21.112	Ph_sician/	6 3	Immediate Cause (Final disease or condition	Di	late	d (2012	lio	myo	hoth	y		Onset and Death
-	Medical Examiner		resulting in death)	Due o (or as	en maren i e		01	Trit.	myo		9		
		er	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	7011	ience fy	an	47	ou (16 20			
	red	Examiner	cause. Enter Underlying Cause (Disease or injury	Duo 10 (01 a.	o a oonooqa	ionido igr		1					
	xecur n and ial-tra		that initiated events resulting in death) Last	Due to (or as	s a consequ	ence of):							
0	cate be executed physician and s the burial-transit	edical		d									
876	ificate ng phy as th		IF FEMALE:										-
Box 68760	h cert tendir or use	an/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom 1 Live Birth		Ideath 3						ate of delive	
Bo	is that the death certifications by the attending is be detached for use as	Physician/M	1 Yes 2 No	4 ☐ Pregnant 9 ☐ Unknowr		leath 5 L	Other (spec	cify)			N	lonth	Day Year
P.O.	at the		Part II. Other significant conditions	s contributing to death	but not resu	ulting in the u	nderlying ca	use given i	in Part I.	23e. Did t	obacco use cor	tribute to th	ne cause of death?
S, T	signe signe d be	d by	Hupen	v tensus	1					1	Yes 2 No	3 🗆 Prot	oably 4 🗆 Unknown
ord	requires been signal	lete	10 miles	rtensul	111	1,1				24a. Was	an 24b	. Were autor	osy findings available
ecc	e has	Completed	- 4019	7 - 0/(7700	1/					psy ormed?	prior to con death?	mpletion of cause of
E	an: Th tifficat tor, p		25. Was case referred to medical					26. Place	of Death (Chec	1 L Yes	2 No	1 L Yes	No No
Ζit	lysici is cer direc	To B	examiner?	Hospital:	atient 2 🗆	ER/Outpatien	nt 3 🗆 DOA	Other:	4 Nursing H	ome 5 Resi	dence 6 🗌 Ot	her (Specify)
of	ng Pł fter th ineral		27. Manner of Death 1 Natural 5 Pending	28a. Date of in (Month, D		28b. Time of injury	280	. Injury at work?		28d. Describe	now injury occu	rred	
ion	tendil leath. lor: Al the fu	ifica	2 Accident Investigat	t be			М	1 🗌 Yes	2 2 No				
Division of Vital Records,	or At after c Direct in by	Certificate:	4 Homicide determine	28e. Place of Ir	njury - At hor etc. <i>(Specify)</i>		eet, factory, c	office		28f. Location (City or Tou	Street and Num. vn, State)	ber or Rural	Route Number,
Ω	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Of the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi		29a. Certifier 1 Certifying P	hysician: To the best of	of my knowle	edge, death o	occurred at th	he time. da	ate and place. a	and due to the c	ause(s) and mar	ner as state	ed.
	ne Ho n 24 } ne Fui	Medical	(Check 2 Medical Exa		examination	and/or invest	tigation, in my	opinion, d	death occurred a	t the time, date	and place, and d	ue to the cau	use(s) and manner stated.
	Vithi Vott		29b. Signature and title of certifier				29c. L	icense nu	mber		29d. Date sign	_	
				7		w		00	258	19	1-	24	-2012
	3		30. Name and address of person wh										_
			Leszek Karo 31. Date filed (Month, Day, Year)	7			-		ve., Ga	itherst	urg, MI	2087	/
	Stat Registra		AN 2.4	00401 20	trar's Signati	ule A	parks						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend State of Marviand / Department of Health and Mental Hygiene

		_	For State St	Certificate			, ,	eg. No. 🤈 (112	03659
ı	Physicia		Decedent's Name (First, Middle, Last) Richard James Campbell				2. Date of Deat January) 1 ^{Vgar}	3. Time of Death
al view	Medic Examir		4a. FacIlity Name (if not institution, give street and number)			ocation of Death	p andary	4c. Count	y of Death	1
	Funeral		Holy Cross Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last bir	irthday)If Under	_	Spring If Under 24 Hrs.	8. Date of Birth		gome 9. Birtl	hplace (State or Foreign
	Director		236-66-8738 1 № M 2 □ F 68 Usual Residence of Decedent	Yrs. Months	Days	Hours Min.	Oct 7,	Year) 1943	West	untry) Virginia
	f show	tor	10a. State 10b. County 10c. City, Tow	wn or Location erick						10d. Inside City Limits
	ne Man or 28a- notifie	Director	10e. Street and Number	10f, Zip (Code		1	0g. Citizen of	What Co.	1X Yes 2 □ No
	is 23a o	Funeral	2537 Mill Race Road		2170	1		USA		
Maryland 21215-0036	ge 1 and 2 should be filed within 72 hours after death with the Maryland tt of Health and Mental Hygiene. It frem 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	þ	11. Marital Status 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 □ No If Yes, Give Year or Dates.	13. Was Decede If Yes, specif		panic Origin? (Spe , Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		ck, White	ican Indian, ^{e, etc.} Black white
15-(72 hou in "natu Aedica	Completed	(Specify only highest grade completed)	a. Decedent's Usual (Give kind of work life. DO NOT user	k done du	ion ring most of worki	ing	16b. Kind of E	3usiness/1	ndustry
212	d within ygiene. her tha it, the l			oliceman				Law er		ement
land	be filed ental H ked ot ic even	To Be	17. Father's Name (First, Middle, Last) Richard Campbell			18. Mother's Name		faiden Surnan	ne)	
Jary	should and M is mar	53	19a. Informant's Name/Relationship (Type, Print)	b. Mailing Address (•	nd Number or Rura	l Route Number,			,
re, N	l and 2 f Health item 27 other to		20a. Method of Disposition 20b. Place of	2537 Mill of Disposition (Name	e of	1		20c. Location		
Baltimore,	permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other:		4 Donation 5 Other (Specify) Stauf	fer Crematory or oth	her place) itory	1-2			,	Maryland
Ball	permit Depart Impor any in once.		21. Signature of Funeral Service Donsee			^{of Facility} Sta mtown Pi				
		_	23a. Part 1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.							Approximate Interval Between
- Lan	Physician/ Medical	i	Immediate Cause (Final disease or condition resulting in death) Aspiration properties of the consequence as a consequence of the consequence of t							Onset and Death
(Innegative	Examiner	٦.	Sequentially list conditions. Esophageal ca	ancer					- 5	
	rted d ansit	amine	cause. Enter Underlying Cause (Disease or injury	of):						
	e execucian and	al Ex	that initiated events resulting in death) Last C. Due to (or as a consequence	of):						
8760	ficate b g physic as the t	Medic	d						\perp	
Division of Vital Records, P.O. Box 68	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit		F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1						ate of deli	very S
ds, P.O	quires that then the signed by ould be deta	ted by Pł	Part II. Other significant conditions contributing to death but not resulting	in the underlying ca	ause giver	n in Part I.				the cause of death?
Recor	To the Hospital or Attending Physician: The law re within 24 hours after death of the Funeral Director: After this certificate has be completely filled in by the funeral director, page 2 sh	Completed	25. Was case referred to medical				24a. Was an autops perform 1 \(\sum \text{Yes} \) 2	y ned%	prior to co death?	opsy findings available ompletion of cause of
Vita	ysicial lis certi	To Be	examiner?	Outpatient 3 DOA	Other:	e of Death (Check	only one) me 5 ☐ Reside	nce 6 🗆 Oth	er (Specii	fv)
n of	ding Pt h. After tt funera		1 ☑ Natural 5 ☐ Pending (Month, Day, Year)	Time of injury M	c. Injury a	at 2	28d. Describe hov	w inj ur y occur	red	
ivisio	l or Atten after deat Director: I in by the	Certificate:	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, fa building, etc. (Specify)				28f. Location (Str. City or Town,		er or Rura	al Route Number,
	Hospita 24 hours Funeral stely filled	Medical	29a. Certifier (Check 2 Medical Examiner: On the best of my knowledge,	or investigation, in my	y opinion,	death occurred at	the time, date and	l place, and du	ie to the ca	ause(s) and manner stated.
	To the within To the Comple		only one) 3 ☐ Certifying Nurse Practitioner: To the best of my kno 29b. Signature and title of certifier		red at the License n			cause(s) and r		
			De Parel Jayanti		005	2586		1/10	1/20	12
	9			(Type, Print) cest Glen	Road	l, Silver	Spring	, Mary	land	20910
1	Stat Registra	-	31. Date filed (Month, Day, Year) JAN 2 4 2012 32. Begistrar's Signature	parker	,					

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

Physicia	an/	Registrar 1. Decedent's Nam		. ,	·	Cei	rtificate of	Dealii		2. Date of De		Year	3. Time of Death
Medi	cal	Walter E.		Jr. n, give street and nur	mher)		4b. City, Town, o	ar Location	of Dogth	Jan	uary 22, 20	nty of Dear	06:00 AM M
Examir	lei	11415 Hot	ffman Ho	llow Rd SW				Frostb	ourg			gany	
Funeral Director	г	5. Social Security N 214-34-12	209	6. Sex 1	7. Age (In yrs	s. last birthday) Yrs.	If Under 1 Year Months Days	If Under Hours	Min.	8. Date of Bit (Month, Da Augu		Co	thplace (State or Foreign ountry) aryland
-f show ed at	ctor	Usual Residence of 10a. State	10b. County			City, Town or Lo	ocation						10d. Inside City Limits
a or 28a oe notifí	I Director	Maryland 10e. Street and Nur		legany 15 Hoffman H		rostburg	10f. Zip Code				10g. Citizen o	of What Co	1 ☐ Yes 2 🗷 No ountry?
mus 23	Funeral	11. Marital Status			edent Ever in U		21532- Was Decedent of F	lienanie Orl	lain? (Sne	noify Voc or No	U.S.A.		
Department of Health and Mental Hygiene. Important: I frem 23a or 28a-f show important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	ρ	1 Never Mari	-	rried Armed Fo	orces? 2 I No ve		If Yes, specify Cub.	an, Mexicar	n, Puerto			Black, Whit	
"natur adical E	Completed		15. Decede	ent's Education est grade completed			dent's Usual Occup		at of worki	ina	16b. Kind of		Industry
giene. er than the Me		Elementary/Sec		O College (Ìife. D	O NOT use retired; y Equipment			9	Constr	uction	
ental Hyg ked oth ic event,	To Be	17. Father's Name (Walter E								e (First, Middle, e Arno	, Maiden Surna ld	ame)	
and Me is mar aumati		19a. Informant's Na					ng Address (Street	and Numbe	er or Rura	l Route Numbe		n, State, Zij	p Code)
Health tem 27 other tr		Phyllis At 20a. Method of Dis		we wife	20b	. Place of Dispo	Hoffman Hollo	ow Rd S		stburg Date	Ma 20c. Locatio	ryland	21532-
ant: If it			Cremation	3 ☐ Removal from Specify)		cemetery, crer	natory or other place of the control			ry 23, 2012	Cumber		Maryland
Departi Import any inj once.		21. Signature of Fu	111	Licensee		22	2. Name and Addre	ss of Facili	ty				
					21		Durst Funer	ral Hom	ie. 57 l	Frost Ave.	. Frostbur	g. MD	21532
		23a. Part 1. Enter t		r complications that only one cause on ea		ath. Do not ente	Durst Funes er the mode of dyir		-			rg, MD	Approximate
Medical		23a. Part 1. Enter t	the disease, o rt failure. List (Final	only one cause on ea	ach line.	lerotic		ng, such as	cardiac c	or respiratory a	rrest,	rg, MD	
Medical	er	23a. Part 1. Enter shock, or hea Immediate Cause disease or condition resulting in death) Sequentially list co	the disease, o ort failure. List (Final on	a. A H	ech line.	lerofic equence of):	er the mode of dyir	ng, such as	cardiac c	or respiratory a	rrest,	rg, MD	Approximate Interval Between
Medical caminer	aminer	23a. Part 1. Enter shock, or hea Immediate Cause disease or condition resulting in death) Sequentially list co if any, leading to in cause. Enter Unde Cause (Disease or	the disease, our failure. List (Final on onditions, namediate wilying iinjury	a. A H	ach line.	lerofic equence of):	er the mode of dyir	ng, such as	cardiac c	or respiratory a	rrest,	rg, MD	Approximate Interval Between
Medical aminer transit	cal Examiner	23a. Part 1. Enter shock, or hea Immediate Cause disease or condition resulting in death) Sequentially list co if any, leading to incause. Enter Unde	the disease, our failure. List (Final on on onditions, namediate or or or or or or or or or or or or or	a. AH Due to b. Due to c.	ech line.	equence of):	er the mode of dyir	ng, such as	cardiac c	or respiratory a	rrest,	rg, MD	Approximate Interval Between
Medical caminer	1- 1	23a. Part 1. Enter shock, or hea Immediate Cause disease or condition resulting in death) Sequentially list coif any, leading to in cause. Enter Unde Cause (Disease or that initiated event resulting in death)	the disease, our failure. List (Final on on onditions, namediate or or or or or or or or or or or or or	a. AH Due to b. Due to c.	Ach line. Hero Scolor as a conse	equence of):	er the mode of dyir	ng, such as	cardiac c	or respiratory a	rrest,	rg, MD	Approximate Interval Between
Medical caminer	1- 1	23a. Part 1. Enter the shock, or hea Immediate Cause disease or condition the shock of the shock	the disease, or failure. List (Final Circum) on ditions, namediate rhying iinjury is Last	b. Due to c. Due to 23c. If yes, ou 1 Live	(or as a conse	equence of): equence of): equence of): equence of):	er the mode of dyir	ng, such as	cardiac c	or respiratory a	23d. I	Date of de Month	Approximate Interval Between Onset and Death 24000
Medical caminer	by Physician/Medical	23a. Part 1. Enter shock, or hea Immediate Cause disease or condition resulting in death) Sequentially list confirm the first cause. Enter Under Cause (Disease or that initiated event resulting in death) IF FEMALE: 23b. Was decedent in the past 12 1 Yes 2 Unknown	the disease, our failure. List (Final Charles on Charle	a. AHA Due to b. Due to c. Due to d. 23c. If yes, ou 1	(or as a conse	equence of): equence of): equence of): equence of): equence of): financy etal death	er the mode of dyin Conoli o Ectopic pregnan Other (specify)	ng, such as	cardiac c	or respiratory and discrete di	23d. I	Date of de Month	Approximate Interval Between Onset and Death 246/1005
Medical kaminer	by Physician/Medical	23a. Part 1. Enter shock, or hea Immediate Cause disease or condition resulting in death) Sequentially list confirm the first cause. Enter Under Cause (Disease or that initiated event resulting in death) IF FEMALE: 23b. Was decedent in the past 12 1 Yes 2 Unknown	the disease, our failure. List (Final Charles on Charle	a. Due to b. Due to c. Due to d. 23c. If yes, ou 1 Live 4 Preg 9 Unk	(or as a conse	equence of): equence of): equence of): equence of): equence of): financy etal death	er the mode of dyin Conoli o Ectopic pregnan Other (specify)	ng, such as	cardiac c	23e. Did t	23d. I	Date of de Month	Approximate Interval Between Onset and Death 24000 Divery Day Year Othe cause of death? robably 4 Munknown
Medical caminer	by Physician/Medical	23a. Part 1. Enter shock, or hea Immediate Cause disease or condition resulting in death) Sequentially list confirm the first cause. Enter Under Cause (Disease or that initiated event resulting in death) IF FEMALE: 23b. Was decedent in the past 12 1 Yes 2 Unknown	the disease, our failure. List (Final Charles on Charle	a. Due to b. Due to c. Due to d. 23c. If yes, ou 1 Live 4 Preg 9 Unk	(or as a conse	equence of): equence of): equence of): equence of): equence of): financy etal death	er the mode of dyin Conoli o Ectopic pregnan Other (specify)	ng, such as	cardiac c	23e. Did t 1 24a. Was auto perfe	23d. I	Date of de Month ontribute to 3 □ P b. Were au prior to a death?	Approximate Interval Between Onset and Death Death Onset and D
Medical caminer	Be Completed by Physician/Medical I	23a. Part 1. Enter shock, or hea Immediate Cause Immediate Cause disease or condition resulting in death) Sequentially list colif any, leading to in cause. Enter Unde Cause (Disease or that initiated event resulting in death) IF FEMALE: 23b. Was decedent in the past 12 1 yes 2 yes Unknown Part II. Other signif	the disease, or failure. List (Final on ditions, namediate rhying linjury is Last	a. Due to b. Due to c. Due to d. 23c. If yes, ou 1 Live 4 Preg. 9 Unk ons contributing to c	(or as a conse	equence of): equen	Ectopic pregnand Other (specify)	cy ven in Part	cardiac c	23e. Did t 1 24a. Was auto perfc 1 Yes	23d. I	Date of de Month ontribute to 3 P b. Were au prior to a death? 1 Yes	Approximate Interval Between Onset and Death Death Onset and D
Medical caminer	To Be Completed by Physician/Medical I	23a. Part 1. Enter shock, or hea Immediate Cause Immediate Cause disease or condition resulting in death) Sequentially list colif any, leading to in cause. Enter Unde Cause (Disease or that initiated event resulting in death) IF FEMALE: 23b. Was decedent in the past 12 1	the disease, or failure. List (Final on ditions, nonditions, nonditions, nonditions, nonditions, nonditions, nonditions, nonditions, nonditions). Last	only one cause on each one on each one cause on each one cause on each one cause on each one cause on each one cause on each one cause one cause on each one cause one	(or as a consection of pregnent at time on onown leath but not real of injury	equence of): equen	Ectopic pregnand Other (specify)	ey ven in Part	I. th (Checkursing Ho	23e. Did t 1 24a. Was auto perfc 1 Yes conly one)	23d. I	Date of de Month b. Were au prior to death? 1 Yes	Approximate Interval Between Onset and Death Death Onset and D
Medical aminer transit	To Be Completed by Physician/Medical I	23a. Part 1. Enter shock, or hea Immediate Cause disease or condition resulting in death) Sequentially list codif any, leading to incause. Enter Under Cause (Disease or that initiated event resulting in death) IF FEMALE: 23b. Was decedent in the past 12 1 Yes 2 9 Unknown Part II. Other significations of the past 12 1 Yes 2 Yes 2 Yes 2 Yes 2 Yes 3 Yes 3 Yes 4 Yes 2 Yes 4	the disease, or failure. List (Final on ditions, namediate rhying iinjury is Last pregnant months? No ficant conditi	only one cause on each one on each one on each one to b. Due to b. Due to c. Due to d. 23c. If yes, our 1 Live 4 Preg 9 Unk ons contributing to conscious contributing conscious contributing conscious contributing conscious contributing conscious contributing conscious contributing conscious contributing conscious contributing conscious contributing conscious contributing conscious contributing conscious contributing conscious contributing contrib	(or as a conse (or as a conse (or as a conse (or as a conse tcome of pregr Birth 2	erofic equence of): equence of)	Ectopic pregnand Other (specify) Inderlying cause gi 26. P at 3 □ DOA 28c. Injur work M □ □	ey ven in Part	I. I. I. Vo	23e. Did t 1 24a. Was auto perfu 1 1 Yes conly one) me 5 Resi	23d. I	Date of de Month ontribute to 3 P b. Were au prior to ? death ? 1 Yes	Approximate Interval Between Onset and Death Death Onset and D
Medical caminer	Certificate: To Be Completed by Physician/Medical I	23a. Part 1. Enter shock, or hea Immediate Caused disease or condition resulting in death) Sequentially list co if any, leading to in cause. Enter Unde Cause (Disease or that initiated event resulting in death) IF FEMALE: 23b. Was decedent in the past 12 1	the disease, or trailure. List (Final on onditions, namediate rhying iinjury is Last pregnant months? No ficant conditi A No h 5 Pendii Investi	a. Due to b. Due to c. Due to d. 23c. If yes, ou 1 Live 4 Prec 9 Unk ons contributing to co	(or as a conse (or as a conse (or as a conse (or as a conse tcome of pregr Birth 2	erofic equence of): equence of)	Ectopic pregnand Other (specify) 26. P 28c. Injur work	cy ven in Part	I. I. I. Vo	23e. Did t 1 24a. Was auto perfu 1 1 Yes conly one) me 5 Resi	23d. In obacco use co Yes 2 No an psy promed? 2 No dence 6 0 0 now injury occu	Date of de Month ontribute to 3 P b. Were au prior to ? death ? 1 Yes	Approximate Interval Between Onset and Death Death Onset and D
Medical caminer	Certificate: To Be Completed by Physician/Medical I	23a. Part 1. Enter shock, or hea Immediate Cause (disease or condition resulting in death) Sequentially list confirmed in the cause (Disease or that initiated event resulting in death) IF FEMALE: 23b. Was decedent in the past 12 1	the disease, or failure. List (Final on ditions, namediate thying iinjury is Last pregnant months? No ficant conditi No Pendi Investi 6 Could detern Certifying Medical I	only one cause on each of the cause on each of the cause on each of the cause on each of the cause on each of the cause on each of the cause of the	(or as a conse (or as a conse (or as a conse (or as a conse (or as a conse tcome of pregr Birth 2	erofic equence of): equence o	Ectopic pregnand Other (specify)	cy ven in Part lace of Dearer: 4 \(\) Nu y at ? Yes 2 \(\)	I. th (Check	23e. Did t 1 24a. Was auto perfet 1 Yes only one 28f. Location (3 City or Tov	23d. I cobacco use co Yes 2 \(\text{No} \) an psy primed? 22 \(\text{No} \) dence 6 \(\text{Q} \) onow injury occu	Date of de Month Date of de M	Approximate Interval Between Onset and Death Death Onset and D
been signed by the attending physician should be detached for use as the buria	To Be Completed by Physician/Medical I	23a. Part 1. Enter shock, or hea Immediate Cause Immediate Cause (disease or condition resulting in death) Sequentially list codif any, leading to in cause. Enter Unde Cause (Disease or that initiated event resulting in death) IF FEMALE: 23b. Was decedent in the past 12 1	the disease, or failure. List (Final on ditions, neediate rhying linjury s Last pregnant months? No ficant conditi No h Certifying Medical linvest 6 Could determ Certifying title of certifie	Due to b. Due to c. Due to d. 23c. If yes, ou 1 Live 4 Preg 9 Unk ons contributing to contrib	(or as a conse (or as a conse	erofic equence of): equence of)	Ectopic pregnand Other (specify) anderlying cause gi 26. P 28c. Injur work M 28c. Injur work 1 eet, factory, office	ey ven in Part lace of Dearer: 4 Nuy at continue and on, death on et time, date	I. I. I. I. I. I. I. I. I. I. I. I. I. I	23e. Did t 1 24a. Was auto perfet 1 Yes only one 28f. Location (3 City or Tov	23d. I cobacco use co Yes 2 \(\text{No} \) an psy primed? 22 \(\text{No} \) dence 6 \(\text{Q} \) onow injury occu	Date of de Month ontribute to a 3 P b. Were au prior to a death 1 Yes other (Specurred onter as stadue to the amanner as as and (Month)	Approximate Interval Between Onset and Death Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Death Onset and Death Death Onset and Death Dea

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 01 2012 MARJORIE ZAIS CARSCADEN 12:15 A.M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death SINCERELY YOURS ASSISTED LIVING CUMBERLAND ALLEGANY If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. Social Security Number Funeral 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 1 □ M 2 🗓 F **Director** 95 Yrs 212-18-1327 MARYLAND 09/26/1916 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director MD ALLEGANY CUMBERLAND 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be Funeral 23a 15900 WILLIAMS ROAD, S.E. 21502 U.S.A. within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. ō ģ 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify. "natural", WHITE Completed 3 Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than ALLEGANY COUNTY Elementary/Seconday (0-12) College (1-4 or 5+) BOARD OF EDUCATION 12 FOOD SERVICE WORKER traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ JOHN F. S. ZAIS SUSAN PATRICK Juge 1 and 2 shc Juger 1 and 2 shc Juger 1 and Important: If item 27 is ma any injury or other 12 spice. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) THOMAS A. CARSCADEN, III /SON 26811 NORTH 161st. ST., SCOTTSDALE, AZ 85262 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🔀 Burial 2 🗌 Cremation 3 🗌 Removal from State cemetery, crematory or other place 4 Donation 5 Other (Specify) SUNSET 01/25/2012 PARK MEML. CUMBERLAND, MD Signature of Funeral Service Licensee 22. Name and Address of Facility UPCHURCH FUNERAL HOME, P.A. 202 GREENE ST., CUMBERLAND, 202 GREENE S1., CUMBERLANT

23a. Part 1. Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or hear failure. List only one cause in each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examir Cause (Disease or iinjury trans and that initiated events resulting in death) Last Due to (or as a consequence of) -purialattending physiciar Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as the IF FEMALE: use yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) Live Birth 2 Fetal death in the past 12 months?

1 Yes 2 No for Pregnant at time of death Month Day the 9 Unknown signed by Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 No 1 🗌 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an certificate has page 2 autopsy perform Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 1 No Assisted မ 1 Inpatient 2 ER/Outpatient 3 DOA this 4 Nursing Home 5 Residence 6 Other (Specify eral Director: After th filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined hours after within 24 hours a To the Funeral C Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Physician: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check To the I

State

as

29b. Signature and title of

(homes 31. Date filed (Month, Day, Year)

5

JAN2

n 23a) (Type, Prir

Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month O Physician/ 13:121 - 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4c. County of Death Lauren 7080 aston 60 5. Social Security Number 6. Sex Funeral 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Months Days Country) MD 1 □ M 2 🕱 F Min. Hours 5-7-1925 **Director** 86 215-20-1795 Usual Residence of Decedent 28a-f shov 10a. State 10b. County with the Maryland notified at 10c. City, Town or Location 10d. Inside City Limits Director Talbot Easton 1 X Yes 2 No 10e. Street and Number ь 10f. Zip Code 10g. Citizen of What Country? Examiner must be Funeral items 23a 7080 Lauren Lane #205 21601 USA filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. ò þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 👿 No Specify: "natural", Completed 3 X Widowed 4 Divorced Specify: White Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Norman A. Eason Dora Robinson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William R. Jones (Son) 8506 Colony Circle Easton MD 21601 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Chesapeake Cremation
Center 20c. Location - City or Town, State ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) /24/2012 Stevensville, MD Signa up of 22. Name and Address of Facility
Fellows, Helfenbein & Newnam Funeral Home, P.A.
200 S. Harrison St. Easton MD 21601 23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one cause hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Onset and Death Physician/ disease or condition oronar uears Medical resulting in death) Due to (or as a consequence f): Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 month 3 Ectopic pregnancy 5 Other (specify) Pregnant at time of death Month Day Year signed by the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗗 Unknown peen: 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an After this certificate has performed? Yes 2 No 1 Yes 2 **N**o 25. Was case referred to dical Be 26. Place of Death (Check only one) Hospital 2 **N**o Other: ၉ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 \(\sum_{\text{Nursing Home}}\) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred ■ Natural injury 5 Pending Accident
Suicide 1 Yes 2 No eral Director: A filled in by the f Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide determined within 24 hours a To the Funeral D Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) Signature 29c. License number -2012

TLS

State Registrar 30. Name and address of person who completed

eal

8221

31. Date filed (Month, Day, Year)

Easton, MD 2160

se of death (Item 23a) (Type, Print)

Registrar's Signature

Cooper, Barbara Ann

			Please Type or						gible.
			1 _ State	f Maryland / Der			Mental Hy		012 03663
			Registrar 1. Decedent's Name (First, Middle, Last)	Ce	ertificate of	Death	2. Date of De	Reg. No. 2	3. Time of Death
a f	Physicia Medic		Barbara Ann Cooper				Janua	ry 09/9,	2012 5852 AM
mark.	Examir	ner	4a. Facility Name (if not institution, give street and num Doctors Community Hospi	•	4b. City, Town, o	or Location of Deat M	th		nty of Death Lnce Georges
10	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)		If Under 24 Hrs		rth	Birthplace (State or Foreign Country)
	Director		219-76-8098 Usual Residence of Decedent 1 ☐ M 2 🔀 F	49 Yrs.			04/30/	/1962	Washington, DC
	aryland a-f sho fied at	Director	10a. State 10b. County Maryland Prince Georges	10c. City, Town or L Lanham	ocation.				10d. Inside City Limits 1 Yes 2 □ No
	the Ma a or 28 be noti	Dir	10e. Street and Number		10f. Zip Code			10g. Citizen of	f What Country?
,	ms 23 must	Funeral	9100 6th Street	L-15 110 Iso	2070			US	
9000	s filed within 72 hours after death with the Maryland that Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Dece Armed For 1 Yes, Given States of Parameters of the States of Parameters	2 LXNo	. Was Decedent of HIf Yes, specify Cub		to Rican, etc.)		ace - American Indian, ack, White, etc. fy: White
15-(72 hou in "nati Medica	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	edent's Usual Occu e kind of work done DO NOT use retired	during most of wo	rking	16b. Kind of	Business/Industry
212	within /giene.		Elementary/Secondary (0-12) College (1- 12 2	4 Or 5+)	ycare Pro			Self E	mployed
and	be filed ental Hy ked oth c even	To Be	17. Father's Name (First, Middle, Last) Willi Kopf			18. Mother's Na	me <i>(Fir</i> st, <i>Middl</i> e	, Maiden Surnan	ne)
Maryland 21215-0036	e 1 and 2 should be file of Health and Mental H If item 27 is marked o r other traumatic eve		19a. Informant's Name/Relationship (Type, Print) Gregory Cooper (Husband)		ling Address (Street	and Number or Ri	ural Route Numb		State, Zip Code)
Baltimore,	e 1 and t of Hea If item or othe		20a. Method of Disposition	20b. Place of Disp cemetery, cre	position (Name of ematory or other pla	ce)	Date	20c. Location	n - City or Town, State
lţim	permit. Page 1 a Department of H Important: If ite any injury or ot		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature	4:	ke Cremato 22. Name and Addre				ville, MD meral Home
Ba	Departing Departing Important in any ir		Municus of	1 - 1	9013 Anna				
	hysician/		23a Part . Enter the disease, or complications that c shock, or heart failure. List only one cause on ear Immediate Cause (Final disease or condition	ch line.	nter the mode of dyin			rrest,	Approximate Interval Between Onset and Death
14	Medical Examiner		resulting in death) Due to (or as a consequence of):					
	- E	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	or as a consequence of j.					2
	executed ian and irial-transit	Examine	Cause (Disease or injury that initiated events c	or as a consequence of):					
09		dical	d						
Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Luneral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the but the but the funeral director.	Physician/Medical	in the past 12 months?		☐ Ectopic pregnan ☐ Other (spec <i>ify</i>) _	су			Date of delivery fonth Day Year
Division of Vital Records, P.O.	ires that the death signed by the atterid be detached for	by	Part II. Other significant conditions contributing to de	ath but not resulting in the	underlying cause gi	ven in Part I.			ntribute to the cause of death?
Sord	aw require: as been si 2 should I	Completed					24a. Was		Were autopsy findings available prior to completion of cause of
Re	r: The k icate h		25. Was case - erred to medical			**	perfe 1 Yes	ormed?	death? 1 ☐ Yes 2 ☐ No
Vita	ysiciar is certii directo	To Be	examine: Hospital:	npatient 2 HR/Outpatie	LOth	lace of Death (Che	ock only one) Home 5 Resi	dence 6 Oth	her (Specify)
on of	To the Hospital or Attending Physician: The law within 24 burus after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	Certificate: 7	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation		of 28c. Injur worl	y at		how injury occur	
ivisi	or Atte after de Directo	Certil		of Injury - At home, farm, st g, etc. (Specify)	treet, factory, office		28f. Location (City or Tox		ber or Rural Route Number,
Ω	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funeral Director.	Medical	29a. Certifier 1 Certifying Physician: To the beautifier 2 Medical Examiner: On the basis	s of examination and/or inve	stigation, in my opini	on, death occurred	at the time, date	and place, and di	ue to the cause(s) and manner stated.
	To the within To the comple		only one) 3 Certifying Nurse Practitioner: 29b. Signature and title of certifier		29c Licens	e number		20d Date signe	ed (Month Day Year)
			Stilley		MDI	1546	15	01-1	19-2012
2	5		30. Name and address of person who completed cause Shobhit Arora, m	or death (Item 23a) (Type, 8 / 1/8	Good K	uckRi	di, La	aham	19-2012 , MD. 20706
	Stal Registra	te ar	31. Date filed (Month, Pay, Year) JAN 2 5 2012	gistrar's Signature	,				
				-					

			1 - For State Registrar	State of Marylan		artment of I rtificate of			giene Reg. N2 0	2 03664
	Physici /Medic	_	1. Decedent's Name (First, Middle, Last) Robert S. Derrick					2. Date of Dea Month January	Day Y	3. Time of Death 11:24 A.M
)	Examir		4a. Facility Name (If not institution, give s			4b. City, Town,		Death	4c. County of	
			Homewood at Crum				erick		Frede	
	Funeral Director		5. Social Security Number 6. Sex 059-12-5074 Usual Residence of Decedent	7. Age (In yrs. 89	Yrs.	If Under 1 Year Months Days		Min. 8. Date of Birt (Month, Da) Dec. 8,	y, Year) 1922	9. Birthplace (State or Foreign Country) New Jersey
	Maryland a-f show	tor	10a. State 10b. County Maryland Frederi		y, Town or Lo					10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	h with the 3a or 28a st be not	Funeral Director	10e. Street and Number 7401 Willow Road			10f. Zip Code 21	702		10g. Citizen of What USA	at Country?
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatin and Mertal Hygiene. Important: if item 27 is marked other than "natural", or itema 23a or 28a-f show any njury or other traumatic event, the Medical Examiner must be notified at ADEC.	by	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 Tyyes 2 ☐ No If Yes, Give Year or Dates:		Was Decedent of If Yes, specify Cub 1 ☐ Yes 2 🕱 No		n? (Specify Yes or No Puerto Rican, etc.)	- 14. Race - Black, Specify:	American Indian, White, etc. white
21215-0036	within 72 ho ene. than "natur he Medical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 12		(Give	dent's Usual Occu kind of work done DO NOT use retire custodi	during most (ad)	of working	16b. Kind of Busin	
Maryland 2	uld be filed Aental Hygi rked other tic event, I	To Be Co	17. Father's Name (First, Middle, Last) Clement Derrick					s Name (First, Middle, rene Pulis	Maiden Surname)	
Mary	and 2 shorell and health and h		19a. Informant's Name/Relationship (Type Dorothy Derrick -					or Rural Route Numberederick, N		ate, Zip Code) 21702
Baltimore,	Pages 1 and of He Int. If Item		20a. Method of Disposition 1 Burial 2 Cremation 3 R 4 Donation 5 Other (Specify)	emoval nom State	auffer	osition (Name of matory or other pla Cremato	ry 1-			, Maryland
Balt	Departi Importu any nje		21. Sign ture of Funeral Service Lonse	ille len				Stauffer I Pike, Fred		
	Physician /Medical Examiner portal-transit	Examiner	23a. Part1. Enter the disease, or complications, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	e cause on each line.	COF juence of): CA7	0 - As			rrest,	Approximate Interval Between Onset and Death Oyes
Box 68760,	irres that the death certificate be executed signed by the attending physician and d be detached for use as the burial-transit	Physician/Medical E	230. Was decedent pregnant	I		⊒Ectopic pregnanc	e y		23d. Date	· ·
P.O. E	t the dea by the att	hysici	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of c 9☐ Unknown	death 5	Other (specify)			Month	h Day Year
rds, F	w requires that been signed should be de	þ	Part II. Other significant conditions con	itributing to death but not res	sulting in the u	nderlying cause g	ven in Part I.	23e. Did t	10	oute to the cause of death?
Il Records,	Attending Physicien: The law requires that the death certifica redath. cidath. ector: After this certificate has been signed by the attending phy the funeral director, page 2 should be detached for use as it by the funeral director.	Completed						24a. Was autor perfo 1 Yes	osy prie	ere autopsy findings available or to completion of cause of ath?
₹	ician Sertifi ector	Be	25. Was case referred to medical examiner?	lospital:		. 0	26. Place o	of Death (Check only o	one)	
Division of Vital	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director Attenthis certificate has completely filled in by the funeral director, page 2	tlon: To	1 Yes 2 No '' 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	1 ☐ Inpatient 2 ☐ 28a. Date of Injury (Month, Day Year)	28b. Time o Injury	f 28c. Inju	4 Nurs		dence 6 Other	
Divisi	ai or Atters after dea il Director	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Special	ome, farm, str	reet, factory, office		28f. Location (. City or Tou		or Rural Route Number,
	To the Hospital or within 24 hours afte To the Funeral Director Completely filled in the Funeral Director of the Funeral Direc	edical C	29a. Certifier 12 Certifying Phys (Check only 2 Medical Examir one)	sician: To the best of my knoner: On the basis of examina and manner stated.	owledge, deat ation and/or in	h occurred at the tvestigation, in my	ime, date and opinion, death	place, and due to the n occurred at the time,	cause(s) and manr date and place, an	ner as stated. Indicate to the cause(s)
	To the within To the comple	×	29b. Signature and title of certifier		-	29c. Licer	ise number		29d. Date signed ((Month, Day, Year)
)			Moyenr			Rioc	0502		1-24-1	2
	181		30. Name and address person who co	impleted cause of death (Iter	m 23a) (Type,		-			
	Śta		31. Date filed (Month, Day, Year)	32, Redistrar's Signi	ature	st. 4	reder	ruc ma	3 2170	1
	Registi		JAN 25 20	12 Jeneur	1. 14	barkel				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ MARY JANE DUCKWORTH Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Western MD Regional Medical Center Cumberland Allegany 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours 10/27/1935 236-42-0166 Maryland Director 1 □ M 2 💢 F 76 Usual Residence of Deceder 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits with the Maryland at Director or than "natural", or items 23a or 28a-fs the Medical Examiner must be notified WV 1 Yes 2 X No Hampshire Green Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral HC 86, Box 33 26722 U.S.A. within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 12. Was Decedent Ever in U.S 14 Bace - American Indian. Armed Forces?

1 Yes 2 X No If Yes, specify Cuban, Mexican, Puerto Rican, etc. 1 Never Married 2 Married þ Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🕅 No Specify. Specify: White 3 X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker HOme Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Russell Charles Riggs Ida Mae Peddit 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Pamela Kimble / Daughter HC 64, Box 455, Romney, WV Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place, 1 KBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Forest GLen Cemetery 01/28/2012 Green Spring, WV 22. Name and Address of Facility Upchurch Funeral HOme, Inc. P.O. Box 1260, Fort Ashby, WV 26719 of Funeral Servio 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Dear Immediate Cause (Final Myound Ph_sician/ week disease or condition Medical resulting in death) **Examiner** Gequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examir Cause (Disease or injury that initiated events resulting in death) Last that the death certificate be executed burial-trar Due to (or as a consequence of) Physician/Medical P.O. Box 68760 the attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Year Month Dav Pregnant at time of death g 🗌 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 No page 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Nnpatient 2 ER/Outpatient 3 DOA မ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After to completely filled in by the funeral 1-Natural 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check

State Registrar 29b. Signature and tit

31. Date filed (Month,

30. Name and address of berson who completed cause of death (Item 23a) (Type, Print)

Kant Ave

32. Registrar's Signature

Partifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29c. License number

29d. Date signed (Month, Day, Year) Jan 24, 2012

Ste. 10), Currebuiland, MD 21502

Registrar

925

Bisher Walsh Rd Camberland MP21502

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SHIN

31. Date filed (Morth, 20)3 ex 2012

MD

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - State of Maryland / Department of Health and Mental Hygiene Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 6:45 PM lanuary **Evelyn** Detwiler Sue 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Meritus Medical Center Hagerstown Washington If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign **Director** 215-64-1165 1 M 2X F 03/01/1954 Maryland Usual Residence of Deced 10a. State 10b. County 10c. City, Town or Location the Maryland at 10d. Inside City Limits Director notified 28a-f 1 🙀 Yes 2 🗌 No Maryland | Washington Hagerstown 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? pe by Funeral Page 1 and 2 should be filed within 72 hours after death with ment of Health and Mental Hygiene. The Tris marked other than "natural", or items 23a must b 18 South Mulberry Street U.S.A. 21740 items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. ıral", or iten Examiner r 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2XX No Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes. Give Specify: Completed 3 Widowed 4 ☐ Divorced White Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) the 10 Homemaker Domestic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Alfred Williams Henson Edith Mulligan 27 is marke traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Candy Stine / Daughter 1630 Beamer Lane Chambersburg, PA 17202 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ot cemetery, crematory or other place) ☐ Burial 2 ☐ Cremation 3 🔀 Removal from State 4 X Donation 5 Other (Specify) Science Care Colorado 2/10/2012 | Aurora, Colorado 21. Sign of Funeral Service Lice 22. Name and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania Ave Hagerstown Maryland 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ nematorne Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of): CERTIFICATION APPROVED BY MFDICAL EXAMINER attending physician and for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Day Month Year ed by the ar Unknown 9 Unknown P.O. been signed the should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 autopsy performed? death? 2 🗌 No Yes 2 No Division of Vital or Attending Physician: funeral director, 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? Other: 1 Pripatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Director: After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \square Homicide determined To the Hospital within 24 hours a To the Funeral D **Medical** 29a. Certifier 1 🚅 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier

State Registrar DHMH 17 Rev 06-2011 Nei

H

We storn MD DK

17

MA

istrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

O'Mal

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 5:20 PM DIGGS ARTHUR В. Januar Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Regional Hospital Prince George's Laurel Laurel 6. Sex If Under 1 Year If Under 24 Hrs. Age (In vrs. last birthday) 8. Date of Birth (Month, Pay, Nov • 6 • 9. Birthplace (State or Foreign Country) **Funeral** 1 🔀 M 2 🗆 F Months Days Hours Director LA 435-22-8728 90 Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2X No MD Prince Georges Laurel 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 20708 8401 N. Point Ct. USA hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

X Yes 2 □ No Black, White, etc. þ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give 1942 1 ☐ Yes 2 🛛 No Specify. Completed 3 Divorced 4 Divorced Specify Black 1945 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Elevator Company 12th Elevator Repairman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Carrie Thomas Arthur Diggs, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Laurel, MD. 20708 8401 N. Point Ct. Kirsta Allen - Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗀 Removal from State cemetery, crematory or other place) MD Veterans Cemetery 1-31-2012 Cheltenham, MD 4 ☐ Donation 5 ☐ Other (Specify) Marshal Tomar Chity Funeral Home of Maryland ichrine 4308 Suitland Rd. Suitlnad, MD 20746 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Bilateral Preumonia Physician disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying piration Examin Cause (Disease or iinjury that initiated events resulting in death) Last or Attending Physician: The law requires that the death certificate be executed -trar and burial attending physician for use as the buria Physician/Medical Tailure Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 XUnknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform ☐ Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 No ျ 1 XInpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) hours after death. neral Director; After this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 2 \square No filled in by the 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a

To the Funeral I

completed filled Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the sest of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29b. Signature and title of certifier D41248 Udnuary 22, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7300 Rodd George I. OKang MD Laurel Regional Hospita

DHMH 17 Rev 7/2009

State Registrar 32. Registrar's Sign

-dure

			_ For	State of Maryla	nd / Depa	artment of H	lealth and	Mental Hy	giene		
		-	State Registrar		Cer	tificate of L	Death		Reg. No. 2 ()	12	03669
	Dhusiaia	_,	1. Decedent's Name (First, Middle, Last)				2. Date of De	eath	Voor	3. Time of Death
	Physicia Medio		Mary Cordella	Edwards				Janua	ry Day 29 á	Year 2	0130 M
	Examin	er	4a. Facility Name (if not institution, give s	11115	ماء	4b. City, Town, o	Location of Deat	h	4c. County of	of Death	
70-25	Funeral		Memorial Hos 5. Social Security Number 6. Sec		aston last birthday)	If Under 1 Year	If Under 24 Hrs	8. Date of Bir	th	9. Birthola	ace (State or Foreign
ą	Director			□ M 2 🗶 F 77	Yrs.	Months Days	Hours Min.	(Month, Da	ay, Year)	Country	1)
	d ow t		Usual Residence of Decedent 10a, State 10b, County	10-0	in Tour			Sept 1	1 1934	Mary!	
	ırylan a-f sh ied a	Director	,		ity, Town or Loc					100	d, Inside City Limits 1 ☐ Yes 2 🌠 No
	he Ma or 28a notif	Dire	Maryland Caroline 10e. Street and Number	e H	enderso	n 10f, Zip Code			10g, Citizen of W	hat Countr	
- 1	with t	Funeral	25341 Hollingswor	th Circle		2164	0		USA		, .
0	death with the Maryland items 23a or 28a-f sho ner must be notified at		11. Marital Status	12. Was Decedent Ever in U	I.S. 13. V	Vas Decedent of H Yes, specify Cuba	ispanic Origin? (S	pecify Yes or No-	14. Race	- Americar	
> 36	after (I", or xamir	d by	1 ☐ Never Married 2 【X Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 █ X No If Yes, Give		☐ Yes 2 XNo				k, White, etc Whit	
2 8	nours atura ical E	lete	15. Decedent's Ed	Year or Dates.	16a, Deced	ent's Usual Occup	ation		16b. Kind of Bus		
√ (0	within 72 hours after giene. er than "natural", or , the Medical Exami	Completed	(Specify only highest grade Elementary/Secondary (0-12)	de completed) College (1-4 or 5+)	(Give k	ind of work done of NOT use retired)	during most of wo	rking	TOD. TAING OF DAY)11000/11100	ion y
27	withi ygiene her th ht, the		08		Time	Keeper:	Persona	1 office	food i	Indust	try
Sand	e filed ntal Hy ed oth event:	To Be	17. Father's Name (First, Middle, Last)						, Maiden Surname)		
2rdS Maryland	12 should be file lith and Mental H 27 is marked or r traumatic eve		Carlton S. Pratt 19a. Informant's Name/Relationship (Type)	ne Printl	10h Mailin	a Adduses (Chrost	Mary		er, City or Town, St	nto Zio Co	of a l
	2 shoulth an 27 is 27 is r trau	Ιi	Alfred J. Edwards		- In-				enderson,		·
DZ re,	1 and of Heal item other		20a. Method of Disposition	20ь.	Place of Dispos			Date	20c. Location -		
$Ed\omega_{\mathcal{L}}$ Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		1 X Burial 2 \square Cremation 3 \square 4 \square Donation 5 \square Other (Specify,	Terrioval from Glate	-	o Cemete		2 2012	Greensbo	oro, N	Maryland
選手円	permit. I Departin Importa any inju once.		21. Signature of Funeral Service License		22	Name and Addres	ss of Facility PO	Box 160); Greens	boro	MD 21639
		Ц	Megh (P.	lugh					neral Hom		
			23a. Part 1. Enter the disease, or compi shock, or heart failure. List only on Immediate Cause (Final	e cause on each line.	atn. Do not ente	r the mode of dyin	g, such as cardiad	or respiratory ar	rest,	11	Approximate nterval Between Onset and Death
	Physician/ Medical		disease or condition resulting in death)	a. Seve	re	Sep	5-3				Shoot and Boath
	Examiner			Perso	marke.	d 6	une	1.			
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as consec	quence of):	1	, ,	+	/ 22		
	cuted ind transi	Examiner	Cause (Disease or injury that initiated events	Large	- bn	vel S	to 1.	mpo	actor		
_	ite be executed hysician and the burial-transit	dical E	resulting in death) Last	Due to for as a Grised	quence oi):	oid	volvi	1140			
760	the the	edic		1	197.	0101	V0100				
687	certifi nding use a	M/M	IF FEMALE: 23b. Was decedent pregnant 2	3c. If yes, outcome of pregn					23d. Date	e of delivery	,
Вох	death e atte	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live Birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown		Other (specify)	У		Mon	th D	ay Year
P.O. E	t the c by th	Phy	9 Unknown		- 141 - 1 - 41	- d- d 1	and Date	T			
σ.	requires that the death certifica been signed by the attending pl should be detached for use as t	Completed by	Part II. Other significant conditions con	O R A D R P D	suiting in the ur	denying cause giv	ren in Part I.		obacco use contrib		bly 4 Unknown
rds	requir been s should	etec	300010	a contract	CV C			24a, Was			y findings available
eco	s ician: The law r certificate has b irector, page 2 s	lduu						auto	psy pr prmed? de	rior to comp eath?	pletion of cause of
<u>~</u>	in: Th ifficate tor, pa		25. Was case referred to medical			26 PL	ace of Death (Che		2 No 1	☐ Yes 2	No
Vits	ysicia is cert direct	To B	examiner? 1 ☐ Yes 2 🔯 No	ospital:	BR/Outpatien	Oth	or.		dence 6 🗌 Other	(Specify)	
Division of Vital Records,	Attending Physician: The law requires that the death certifica redeath. Ar death ar death ear death ear bear signed by the attending portor After this certificate has been signed by the funeral director, page 2 should be detached for use as the funeral director.		27. Manner of Death 1 ✓ Natural 5 ☐ Pending	28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury work	/ at		how injury occurred		
ion	ttendii death. stor: Ai y the fu	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be	an Bi (iii ai)			Yes 2 ☐ No				
<u>ivi</u>	or At after of Direct in by	Cert	4 Homicide determined	28e. Place of Injury - At h building, etc. (Specia	iome, farm, stre fy)	et, factory, office		28f. Location (S City or Tov	Street and Number vn, State)	or Rural R	oute Number,
Ω	To the Hospital or Attending Physiciam: Within 24 hours after death. To the Funeral Director After this certific completely filled in by the funeral director.	ical		cian: To the best of my know							
	ne Ho in 24 I ne Fu	Medical	(Check 2 Medical Examin only one) 3 Certifying Nurse	Practitioner: To the best of	on and/or investi my knowledge,	gation, in my opinic death occurred at t	n, death occurred he time, date and p	at the time, date a place, and due to	and place, and due the cause(s) and ma	to the cause anner as sta	e(s) and manner stated. ited.
	To the vithing common c		29b. Signature and title of certifier	Pourt		29c. License			29d. Date signed	(Month, Da	y, Year)
)						2593		01/28	112	
			30. Name and address of person who co	impleted cause of death (Iter	m 23a) (Type, Pi	int)					
	Stat	e	31. Date filed (Month, Day, Year)	32. Registrar's Signa		7					
	Registra	ar	JAN 31 2012	paragrap 18.	Maria						

DHMH 17 Rev 06-2011

AS 6

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Monthuary Day 2012 Physician/ Рм 7:10 Mary Valinda Franklin Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Frederick **Examiner** 4c. County of Peathick Frederick Memorial Hospital Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours (Month, Day, Year) 212-24-3970 **Director** 1 🗆 M 2 🗓 F 96 Oct. 21, 1915 Maryland Usual Residence of Deced 28a-f show or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland | Montgomery Damascus 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 27440 Clarksburg Road U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Race - American Indian, Black, White, etc. 11. Marital Status Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. 1 Never Married 2 Married ģ Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: Specify: 3 X Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygie Important. If item 27 is marked other any injury or other traumatic event, tt Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Burdette Sherman W. T. Mullinix Valinda 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Debra Sturm - Daughter 1711 Park Avenue, Halethorpe, Maryland 21224 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1X Burial 2 Cremation 3 Removal from State 4 Denation 5 Other (Specify) 1/26/2012 Browningsville, Maryland Bethesda Cemetery 21. Signatu e of Fu eral Service icen Molesworth-Williams P.A., Funeral Home Covert 26401 Ridge Road, Damascus, Maryland 20872 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph. sician/ 30. RE DAY disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year Pregnant at time of death the i signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Hospital or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 s performed certificate 1 Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 1 🔲 Yes 2 WNo ၉ 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral di 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 \square Pending work? 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 23 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number 29d, Date signed (Month, Day, Year) WDD MADRID 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FREDERICK MEMORIAL AD0 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible, State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Maria E. Fisch 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death 5A456419 Mamics REGIONAL TENINSHUA If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthdav 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Days (Month, Day, Year) 213-44-0783 Director 1 □ M 2 💢 F 72 Mar. 8,1939 Germany Usual Residence of Decedent 28a-f show must be notified at 10a State 10c. City, Town or Location 10d. Inside City Limits Director 1X Yes 2 □ No Seaford DE Sussex 10e. Street and Numbe ō 10f. Zip Code 10g. Citizen of What Country? 19973 23a Funeral 7732 Gaye Drive United States items ; death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, er than "natural", or iter the Medical Examiner Armed Forces Black, White, etc. þ 1 Never Married 2 Married 2 **X**Vo Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify Specify. White Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Homemaker other 4 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fishers ဂ္ Eva Kraus Alois Kemmerer other traumatic 1 and 2 should b 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health an Important: If item 27 is any injury or other trau Robert M. Fisch/Spouse 7732 Gaye Drive, Seaford, DE 19973 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Durial 2 Cremation 3 Removal from State Hurlock, Maryland Eastern Sh. Veterans Cem. 01/24/12 4 Donation 5 Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility Framptom Funeral Home, P.A. 216 N. Main St., Federalsburg, MD 21632 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ tasta disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Year the 9 ☐ Unknown q Unknown P.O. þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ To the Hospital or Attending Physician: The law requires Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ZÜnknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? certificate 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 Yes 2 No ၉ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1X Natural 5 Pending r death. 1 ☐ Yes 2 ☐ No iours after death.

Ieral Director: A
filled in by the fi Accident Investigation 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide determined 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check within 24

To the F

complete only one 3 X Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 06-2011

State Registrar

AS W

P.R.M

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Idmann

GRNP

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death FEB.3, Physician/ HENRY HERMAN GEHRING, JR. 201 2:33A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ST.MARY'S LEONARDTOWN ST.MARY'S HOSPITAL If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** 1 X M 2 🗆 F Months Days Hours 9 2 - 1 9 2 8 213-24-3186 83 Yrs Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show once. 10a. State 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** ST. MARY'S CHARLOTTE HALL MD. 1 Tes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 29449 CHARLOTTE HALL ROAD 20622 U.S.A. 12. Was Decedent Ever in U.S.
Armed Forces?

1 X Yes 2 No ARMY
If Yes, Give KORFA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 🙀 No Specify: Completed 3 Widowed 4 Divorced KOREA Specify:WHITE Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) SOUTHERN MD. Elementary/Seconday (0-12) College (1-4 or 5+) ELECTRIC COOP STORE KEEPER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ BARBARA HOFFMAN HERMAN GEHRING 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JUDY BROWN-DAUGHTER 5735 COLD LAKE DR. WELCOME, MD. 20693 20b. Place of Disposition (Name of cemetery, crematory or other place)
ST.MARY S CEMETERY 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2-7-2012 BRYANTOWN, MD. 21. Signature Funeral Service Licensee M00479 RAYMOND FUNERAL SERVICE, P.A. LA PLATA, MARYLAND 20646 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Priysician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Dav Year Pregnant at time of death g Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autonsy 1 Yes 2 No Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No Hospital: Other: 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 🗆 DOA 4 Nursing Home 5 Residence 6 Other (Specify, this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred iniury work?
1 Yes 2 No 1 Natural 5 Pending Director: / Accident Investigation □ Accider
 □ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined 4 Homicide City or Town, State) within 24 hours a

To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29d, Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Y

State Registrar 32. Registrar's

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JANUARY RONALD LEE GRAVITT 2012 6:35 Рм Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death **Examiner** 4c. County of Death FREDERICK MEMORIAL If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) lf Under Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth Hours Month 1 **X** M 2 □ F **Director** 160-34-4105 03/01/1942 PA 69 Usual Residence of Deced 28a-f show 10a. State 10b. County notified at 10c. City, Town or Location 10d. Inside City Limits Director Monrovia 1 ☐ Yes 2 No MD Frederick 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mertall Hygiene.

The moundant if the maz's is an amaked other than "natural", or items 23a or introductant; if them 27 is an anyted other than "natural", or other traumatic event, the Medical Examiner must be an any injury or other traumatic event, the Medical Examiner must be a Funeral USA 3823 Greenridge Dr. 21770 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, rmed Forces?
Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates. 3 Widowed 4 Divorced Specify: Completed White 1959-62 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) should be filed with h and Mental Hygien is marked other th 12 construction owner Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Roscoe Gravitt Marion Smouse 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Gravitt/wife 3823 Greenridge Dr., Monrovia, MD 21770 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Page 1 1 $\stackrel{\mathbf{K}}{\blacksquare}$ Burial 2 \square Cremation 3 \square Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) 01/28/2012 Resthaven Mem. Gar. Frederick, MD 22. Name and Address of Facility Stauffer Funeral Homes, P.A. ure of Funeral Service Licensee (lo 1621 Opossumtown Pike, Frederick, MD 21702 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause are each line. Interval Between Onset and Death Immediate Cause (Final Physician) disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events sician and burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 phys s the l as ding IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Pregnant at time of death signed by the ar 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an has page perform After this certificate 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Inpatient 2 Other: 1 Yes ျ ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fi 1 Tyes 2 No Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State, Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one Signature and e of certifier 29d. Date signed (Morth, Day, Year) OXI who completed cause of death (Item) 23a) (Type, Print)

State

31. Date filed (Month. Day.

Year)

25

Registrar DHMH 17 Rev 06-2011 32. Registrar's Signature

7th St. Frederick MD 2170

12-00752 Deborah Griffith

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2012 03674 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle, Last) Physician/ 2. Date of Death Month **Medical Examiner** 1021 hrs Deborah January 26, 2012 Griffith 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death 6 Thompson Court Boonsboro Washington 5. Social Security Number 6. Sex 7. Age (In yrs, last birthday) If Under 1 Year If Under 24Hrs. 8, Date of Birth(MM/DD/YYYY) 9, Birthplace (State or **Funeral** Director Months Davs Hours Country Maryland 212-76-4424 1 M 2 X F Yrs 54 1957 June 8, Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits items 23a or 28a-f show 1 X Yes 2 No Marvland Washington Boonsboro death with the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 Thompson Court 21713 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 12, Was Decedent Ever in U.S. 14. Race - American Indien, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces' White, etc. 1 Never Married 2 X Married 2 X No Yes "natural", or Baltimore, MD 21215-0036
pemit. Pages I and 2 should be filed within 72 hours after of
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", on
iglary or other trannatic event, the Medical Examiner 3 Widowed 4 Divorced if Yes, Give Year Yes 2 X No specify: White <u>≨</u> 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Tendler Gloria Woerner ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James D. Griffith/husband Thompson Court Boonsboro, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify. Fairview Cemetery 01-31-2012 Keedysville, Maryland 22. Name and Address of Facility Bast-Stauffer Funeral Home, PA 21. Signature of Funeral Service Lic 7606_Old National Pike Boonsboro, MD Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fail, le. List only one cause on each line Multiple drug toxicity involving oxymorphone, Approximate Interval **Physician** Between Onset and /Medical Death Immediate Cause (Final disease zolpidem and Quetiapine £xamine or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause Examine Due to (or as a consequence of): (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical X UNPENDED AMENDED 23a, 27, 28a-f, per me, g924 2-28-12 sm attending physician or use as the burial The law requires that the death certificate be Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 3b. Was decedent pregnant in the 1 Live birth 2 Fetal death Day past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown led by the s Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 ✓ No 3 Probably 4 Unknown Completed should 24a Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy has performed? this certificate ✓ Yes 2 No 1 Yes 2 No the Hospital or Attending Physician: 25. Was case referred to medica 26 Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 🗹 Other: Scene 1 Yes ٥ 2 No After the 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 Natural unknown 5 Pending 1 Yes 2 X No fd 9:55 am fd 1-26-12 2 ___ Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Thompson Ct. Boonsboro, MD. 3 Suicide 6 X Could not be determined (Specify) Found at Residence Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. January 27, 2012 elele 30. Name and address of person who completed cause of death (Item 23a) W-0 Victor Weedn MD JD 900 W. Baltimore Street, Baltimore, MD 21223 Assistant Medical Examiner 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registra

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 03675 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death John Andrew Gulick 286 20 9a2 Physician/ Jamuary 11:15A_M Medical 4b. City, Town, or Location of Death Easton 4a Facility Name (if not institution give street and number)
Genesis Health Care-The Pines 4c. County of Death Examiner If Under 1 Year | If Under 24 Hrs | Days | Hours | Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year 1 😾 M 2 🗆 F 236-72-4630 64 Ohio Director 13 Usual Residence of Decedent or 28a-f shov 10b. County 10d. Inside City Limits 10a. State filed within 72 hours after death with the Maryland r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location Director Preston Caroline 1 Yes 2 X No MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21655 Funeral 3110 Backlanding Road United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian Black, White, etc. þ 1 Never Married 2 Married Yes 2 No John Gulick Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: White Completed 3 Divorced 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7: Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Board of Education Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Educator Caroline County Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Michael Gulick Anna Marut 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3110 Backlanding Road, Preston, MD 21655 Janellen Gulick/Spouse 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Preston, Maryland 01/29/12 Junior Order Cemetery: 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Framptom Funeral Home, P.A. 21. Signature of Funeral Service Licensee 216 N. Main St., Federalsburg, MD 21632 Holorice CFSP 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each hie. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) bakis Medical Examiner HRAYS Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a con equence of) attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death the g ☐ Unknown 9 Unknown cate has been signed by a page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed? Yes 2 No death? this certificate 1 Yes 2 No Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 No Hospital Other: မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No n 24 hours after death.

e Funeral Director: After deted filled in by the fun Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2. 3 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number

Registrar

DHMH 17 Rev 7/2009

State

610 Dutchmans

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Phil Anthony Gentilcore 201. 2009 () Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington Adventist Hospital Takoma Park Montgomery If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Days (Month, Day, Year) Director 579-16-9798 1 🕱 M 2 🗆 F 88 April 11, 1923|Washington, DC 28a-f shov 10a. State 10b. County 10c. City, Town or Location the Medical Examiner must be notified at Director 1 X Yes 2 No MD Prince George's Hyattsville 10e. Street and Number 10f. Zip Code 0 10g. Citizen of What Country? 23a Funeral 20782 **IISA** 5819 Maryhurst Drive items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces? þ o 1 Never Married 2 Married ^{2 □} № Navy X Yes Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give "natural", 3 Widowed 4 Divorced Specify: White Completed Year or Dates. 1943-1946 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Hygiene. other than Elementary/Secondary (0-12) College (1-4 or 5+) should be filed with and Mental Hygien is marked other th Production Manager Evening Star 9 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Antonio Gentilcore Vita Corlone other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health ar Important: If item 27 is: Leonard Gentilcore / Son 3615 Little Neck Drive, Edgewater, MD 21037 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Mount Olivet Cemetery 1/30/2012 Washington, DC 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 4739 Baltimore Avenue Gasch's Funeral Home, P.A. Hyattsville, MD 20781 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ a METHICILLIN RESISTANT STAPHYLOCUCUS disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of). The law requires that the death certificate be executed and I-tran resulting in death) Last Due to (or as a consequence of) physician a s the burial-Physician/Medical Box 68760 as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ___ for in the past 12 months?
1 ☐ Yes 2 ☐ No Dav Year Pregnant at time of death 9 Unknown the Linknown P.0. signed by detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by PROTEUS MIRABILIS URIMARY TRACT INFECTION Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? INEUMONIA 24a. Was an has autopsy performed certificate 2 No Yes 2 No 1 Yes eral Director: After this certific filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 🗌 Yes 2 1 No ဂ္ 1 Impatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural (Month, Day, Year) work?
1 Yes 2 No 5 Pending Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined hours after Hospital 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

10+1 State

> Registrar DHMH 17 Rev 06-2011

3 L

SMBYNSACHI

reuser

wen

KAR

ress of person who completed cause of death (Item 23a) (Type, Print)

32. Register's Sig

29b. Signature and title of certified

30. Name and addr

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

D0063703

7600 CACROLL

01/24/2012 AUENUE

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		-	For State Registrar		State of Ma		partment of F ertificate of L			Reg. No.	012	03677
	Physicia		1. Decedent's Name (F)		· · ·		2. Date of De Month	ath Day ary 16, 20	Year	3. Time of Death
	Medio Examin		4a. Facility Name (if no		street and number)			r Location of Death		4c. Cour	nty of Death	
عمدر	_		16612 Ocean 5. Social Security Num		γ 7 Ασσ	e (In yrs. last birthda		Frostburg If Under 24 Hrs.	8. Date of Bir	Alleg		nplace (State or Foreign
	Funeral Director		220-58-0170 Usual Residence of De	1 [© M 2 □ F	60 Yrs	Months Davs	Hours Min.	(Month, Da September	v, Year)	_ Cou	ntry) yland
	and show dat	ē		0b. County		10c. City, Town or	Location					10d. Inside City Limits
	Maryl 28a-f otifie	irec	Maryland	Allegany	r	Frostburg						1 🗶 Yes 2 🗌 No
	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertall Hygiene. Department of Health and Mertall Hygiene. The most properties of the time and the time with an "natural", or items 23a or 28a-f show mortant: I fire marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral Director	10e. Street and Number	er 16612 Oce	ean View Lan	e	10f. Zip Code 21532-			10g. Citizen ou U.S.A.	of What Cou	untry?
	death r items	Fun,	11. Marital Status		12. Was Decedent E Armed Forces?	ever in U.S. 1	3. Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. F	Race - Ameri Black, White,	
036	s after ral", o Exam	ed by	1 Never Married 3 Widowed 4		1 ☐ Yes 2 🔼 If Yes, Give Year or Dates.	No	1 ☐ Yes 2 🔊 No	Specify:		Spec	eify: Whi	te
2-0	2 hour "natu edical	Completed		15. Decedent's Ed fy only highest grad		(G	cedent's Usual Occup ve kind of work done	eation during most of work	king	16b. Kind of		
7	ithin 7 iene. r than the Ma	Com	Elementary/Second	day (0-12)	College (1-4 or 5)+)	. DO NOT use retired) iction Counsel	or		State of	MD	
Maryland 21215-0036	filed w al Hyg d othe event,	Be	17. Father's Name (First	st, Middle, Last)				18. Mother's Nam			ame)	
ryla	uld be d Ment marke natic (٦	John R. Hug		D.1.1			Shirley Od				
Ma	12 sho alth and 27 is I	l	John R. Hug		father		ailing Address (Street of Ocean View La		al Route Numbe stburg		n, State, Zip ryland	21532-
Baltimore,	of Hea of Hea if item r othe		20a. Method of Dispos	sition	Removal from State	20b. Place of Di	sposition (Name of trematory or other place		Date	20c. Locatio	on - City or T	Town, State
ţ <u>ı</u>	t. Page tment rtant: I		4 Donation 5	Other (Specify)	1	land Crematory	1/2	1/2012	Cumber	land N	Maryland
Ba	permi Depar Impor any ir		21. Signature of Fune	Service License			22. Name and Addre Durst Funera		Frost Ave.,	Frostburg	g, MD	21532
П				failure. List only on	e cause on each line	the death. Do not e	enter the mode of dyin	g, such as cardiac	or respiratory ar	rest,		Approximate Interval Between
F	Ph_sician/ Medical		Immediate Cause (Fir disease or condition resulting in death)	METTASIA	U		S CON	CAIZC	NOM	4	- 8	Onset and Death
	Examiner				Due to (or as a	a consequence of):						F
	n #	Examiner	Sequentially list cond if any, leading to innu- cause. Enter Underlyi	iediate ing	Due to (or as a	a consequence oij.						
	ecuter and Il-trans	Exan	Cause (Disease or iinj that initiated events resulting in death) Las		c. Due to (or as a	a consequence of):						
0	certificate be executed nding physician and use as the burial-transit	edical			d							
68760	rtificat ing ph e as th		IF FEMALE:		20 15	,						
Box	eath certifica attending p	Physician/N	23b. Was decedent proint the past 12 mo	onths?	4 Pregnant a	2 Fetal death	3 ☐ Ectopic pregnand 5 ☐ Other (specify) _	су		1	Date of deli Month	very Day Year
P.O. B	es that the des signed by the a I be detached f	Phys	g 🗌 Unknown		9 Unknown				1			
S, P.	Hospital or Attending Physician: The law requires that the death 24 hours after death. However the Hospital Director, After this certificate has been signed by the attereted filled in by the funeral director, page 2 should be detached for a	þ	Part II. Other significa	ant conditions co	ntributing to death b	ut not resulting in tr	ie underlying cause gi	ven in Part I.				the cause of death?
Records,	law req has bee e 2 shou	Completed							24a. Was auto		b. Were auto prior to c death?	opsy findings available ompletion of cause of
	sician: The law certificate has b irector, page 2 s		25. Was case referred	to medical			26 P	lace of Death (Chec	1 Tes		1 Yes	2 🗆 No
Zit2	nysicie lis cert direct	To Be	examiner? 1 Yes 2	MO [+	lospital: 1 ☐ Inpatio	ent 2 ER/Outpa	_ Oth	ori	ome 5 DResi	dence 6 □ C	Other (Specia	fy)
Division of Vital	iding Ph th. After th funeral		27. Manner Death 1 Natural 2 Accident	5 Pending Investigation	28a. Date of inju (Month, Day		y work	y at <br Yes 2 □ No	28d. Describe I	how injury occ	urred	-
visio	I or Attendi safter death Director: A d in by the fi	Certificate:		6 Could not be determined	28e. Place of Inju- building, etc		street, factory, office		28f. Location (mber or Rura	al Route Number,
٥	bopital hours a hours a ineral C	Medical (th occured at the time					
	To the Hosp within 24 ho To the Fune completed fi	Mec	only one) 3	Certifying Nurse			e, death occurred at the	e time, date and pla	ce, and due to th	ne cause(s) and	manner as s	
	6		29b. Signature and titl		THYS	ICAM	29c. Licens	50844		29d. Date sig) [[[7/2012
	nes		30. Name and address	s of person who co	ompleted cause of d	eath (Item 23a) (Typ	e, Print)	Mi) 9	12 for	in Dri	VE CUI	, Day, Year) 7/2012 Mberland MD 21502
Ü	Stat Registra	te ar	31. Date filed (Mark)	Day 20012	32. Registra	ar's Signature	the	<u> </u>	, NI	, ,	- 0	21502

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Certificate of Death Registrar Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 1125 AM Hersher Z6, JANUARI 201z OSCAT! Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Hogerstown MD Washin Centra Maritus Medical If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Director 80 220-26-7364 1**X** M 2 □ F Maryland 07/24/1931 Usual Residence of Deced or 28a-f show notified at 10d. Inside City Limits 10a. State 10b. Count 10c. City, Town or Location within 72 hours after death with the Maryland Director 1 X Yes 2 No Hagerstown Maryland Washington 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? ō r items 23a or ner must be n Funeral 115 N. Potomac St. 21740 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, er than "natural", or iter the Medical Examiner Armed Forces?

1 Yes 2 No Black, White, etc by 1 Never Married 2X Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give 3 Widowed 4 Divorced Completed White Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 12 should be filed withi lith and Mental Hygien 27 is marked other the r traumatic event, the Manufacturing 6 Material Handler Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Eva Florence Miller John Oscar Hershey permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jack Hill / Friend 19400 Spring Valley Dr. Hagerstown, Maryland 21742 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 💢 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rest Haven Cemetery 1/30/2012 Hagerstown, Maryland 21. Sign of Funeral Service Licer 22. Name and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania Ave. Hagerstown Maryland 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Medical disease or condition resulting in death) Examiner OFONA Sequentially list conditions, Examine if any leading to immedicause. Enter Underlying Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events and burial-trar Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as the l IF FEMALE use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy for in the past 12 months? Month Dav Year Pregnant at time of death signed by the a 1 Yes 2 g Unknown 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> Mitral valve 2 **V** No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? mediastisiti) 24a. Was an autopsy perform 1 Yes 2 No 24 hours after death.

Funeral Director: After this certificately filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner?
1 \(\sum \) Yes 2 \(\sum \) No Hospital 1 Inpatient 2 🗆 ER/Outpatient 3 DOA မ 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28c. Injury at 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: 1 🗹 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide completely filled Medical 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one 29b. Signature and title of certifier 27, 2012 67246 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hagerstown, 21740 Christopher

DHMH 17 Rev 06-2011

State

Registrar

31. Date filed (Month, Day, Year,

JAN30

32. Registrar's Signature

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

			Plea	ise Type or Pr					-		•	.
		For State		State of M	larylan		partment of F ertificate of D		d Mental Hy		001	0 00670
		Registrar 1. Decedent's Name	e (First, Middle	, Last)			ertificate of L	Jean I	2. Date of De	Reg. No eath	201	3. Time of Death
Physicia Medi		Arbutus	Mar	y Hollinge	er				Januar	y 27	, 2012	01:30 A M
Exami				, give street and number)			4b. City, Town, or		eath		County of De	
Funeral		MILLIAMS 5. Social Security No		ursing Home 6. Sex _ 7. Ac	ge (In yrs. Ia	st birthda		If Under 24 F		rth		irthplace (State or Foreign
Director		220-40-24		1 □ M 2 X F	80	Yrs	Months Days	Hours M	in. 1/15/1	932	Mic	ountry) chigan
and show lat	or	Usual Residence of 10a. State	10b. County		10c. City	, Town or	Location					10d. Inside City Limits
Maryl. 28a-f otifiec	irect	Maryland	Washir	ngton	Mau	ıgans	ville				- ·	1 X Yes 2 □ No
ith the 23a or at be n	Funeral Director	10e. Street and Nun					10f. Zip Code				tizen of What (Country?
ems 2	nue	14040 Vi 11. Marital Status	llage N	Mill Drive 12. Was Decedent		5, 1	21767 3. Was Decedent of Hi	spanic Origin?	(Specify Yes or No		S . A . 14. Race - An	nerican Indian,
after de	by	1 Never Marri		If Ven Cive	No		If Yes, specify Cuba 1 ☐ Yes 2X No		erto Hican, etc.)		Black, Wh Specify: W	ite, etc. hite
nours a natural ical Ex	Completed	3 🗓 Widowed		Year or Dates.		16a. De	cedent's Usual Occup	ation			ind of Busines	-
iin 72 t ie. han "r e Med	dwo	Elementary/Seco		est grade completed) College (1-4 or	5+)		ive kind of work done on DO NOT use retired)	luring most of v	vorking			
Hygier Hygier Ither t	BeC	12 17. Father's Name (i	First Middle I	ast)			Baker	18 Mother's I	Name (First, Middle	_	rocery	
l be fill lental rked c	P	Roy Ora		,					Ruth Dur		Garriar.roj	
should and N is ma auma		19a. Informant's Na	ame/Relationsh	hip (Type, Print)		19b. M	ailing Address (Street a	and Number or	Rural Route Numb	er, City or	Town, State, 2	Zip Code)
and 2 Health em 27 ther tr		Donald C		inger / Son	20h P				ring Dr.		ncast1	e, PA 17225
age 1 ent of nt: If it			☐ Cremation	3 ☐ Removal from State			sposition (Name of Ten Ghyua ch er p Ge ding Bible		31/2012		-	n, Maryland
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any once.		21. Signature of Fu	-		DIO	adioi	22. Name and Addres					
로 스 트 늄 링		1	K.	12~~		Da					town M	aryland 21742
Dhysisian			rt failure. List o	complications that cause only one cause on each lin	ne.					irest,		Approximate Interval Between Onset and Death
Physician/ Medical		disease or condition resulting in death)	on	Due to (or as			EBBAL T	KEDING	U>(>			EWER'S
Examiner	je.	Sequentially list co	nditions,	b. —	_				. –			
red nsit	Examiner	if any, leading to in cause. Enter Unde Cause (Disease or	rlying iinjury	Due to (or as	a consequ	ience of):						
executed an and rial-transit	Exa	that initiated event resulting in death)		Due to (or as	a consequ	ience of):						
ate be physicia the bu	dica			d								
ath certificate be executed attending physician and for use as the burial-transit	Physician/Medica	IF FEMALE: 23b. Was decedent	pregnant	23c. If yes, outcom							23d. Date of o	delivery
death ne atte ed for	sicia	in the past 12 1	No	1	at time of d		3 ☐ Ectopic pregnand 5 ☐ Other (specify)	У			Month	Day Year
requires that the de been signed by the should be detached	Phy	9 Unknown Part II. Other signif		ons contributing to death		ulting in th	ne underlying cause giv	ven in Part I.	23e. Did	tobacco i	use contribute	to the cause of death?
uires th signe Ild be o	ed by								_ 1□	Yes 2	₹ No 3□	Probably 4 🗌 Unknown
w requas beer 2 shou	Completed								24a. Was	s an		autopsy findings available o completion of cause of
The la	Com									formed?	death'	
slcian certifi irector	o Be	25. Was case referrence examiner? 1 \sum Yes 2	ed to medical	Hospital:	4i4 0 M	EB/Out-	_ Oth	ace of Death (C		:-l (Oth/0-	
ig Phy ter this neral d	te: To	27. Manner of Deat	h	28a. Date of in	ury	28b. Tim		y at	g Home 5 Res 28d. Describe			эспу)
tendir Jeath. tor: Af the fur	Certificate:	1 Natural 2 Accident 3 Suicide	5 ☐ Pendir Investi 6 ☐ Could	igation			M 1 🗆	Yes 2 No				
I or Attendi after death. Director: A I in by the fu		4 Homicide	determ		tc. (Specify		street, factory, office			(Street an wn, State		Rural Route Number,
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the bu	Medical	29a. Certifier 1 (Check 2		g Physician: To the best of								stated. e cause(s) and manner stated.
the Hithin 24	Me		Certifying	g Nurse Practioner: To th				e time, date and		he cause(as stated.
P ≥ P 8	_	1	MAY	e ms				700		Jone	wru 27	7017
ميد ا				who completed cause of	death (Item	23а) (Тур	e. Print)		4			
V-5	10	Ted How 31. Date filed (Mont			rar's Signat	\$7.	MICHA	NSPORT	, MD	217	15	
Sta Regist			JAM 3	0 2012 32. Regist	acres.	A.	park					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #5 Per FH G925 3/13/2012 JH State of Maryland Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Montl Margaret Hornung 2030 Medical 201 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Meritus Medical Center Hagerstown Washington Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Months 1 M 2 X F Days Hours 10/13/1916 Director 193-03-1078 95 Pennsylvania Usual Residence of Decedent 10b. County with the Maryland 10a. State notified at Director 10c. City, Town or Location 10d. Inside City Limits 28a-f 1 Tes 2 X No Maryland Washington Hagerstown 5 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a o Examiner must be Funeral 2009 Rosebank Way 21742 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 X No Black, White, etc. Completed by 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after unent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes Give 3 X Widowed 4 Divorced Year or Dates White th and Mental Hygiene.
It is marked other than "natur traumatic event, the Medical" 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+ 12 Laborer Manufacturing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Willia_m Ε. Droney Dorothy Brissee 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ruth Lauer / Daughter 100 Keyes Rd. #323 Concord, MA 01742 altimore, 20a. Method of Disposition Department of H Important: If ite any injury or oth 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Mark Catholic Cem. 2/2/2012 Emporium Pennsylvania Signature of Funeral Service Licenses 22. Name and Address of Facility Rest Haven Funeral Chapel once 5 6-1601 Pennsylvania Ave. Hagerstown MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Pulmonary Physician/ nool Medical Due to (or as a consequence Examiner CNSID Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Physician/Medical requires that the death certificate be & mamoraneus IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Pregnant at time of death Month Day Yes 2 No signed by the a d be detached f 1 ☐ Yes 2 ☐ 9 ☐ Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an this certificate has I autopsy page 2 🗌 No 25. Was case referred to medical director, Be 26. Place of Death (Check only one) examiner's 1 Yes 2 A16 2 Other: 1 Department 2 ER/Outpatient 3 DDA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work? 2 No Accident Investigation

Box 68760 Division of Vital Records, P.O. To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dir

12

Medical

3 ☐ Suicide 4 ☐ Homicide

only one)

29b. Signature and title of certifier

29a, Certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MURSH FAR, 31. Date filed (Month, Day, Year)

human

2012

6 Could not be

determined

32. Registrar's Signature 2-11-572 to 48....

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Dark

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

112

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

060396

USEL

17

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

21740

State

Registrar

			1 - State of Maryland / Depar Certification	tment of Health and N <i>ficate of Death</i>	Mental Hygiene Reg. No. 20	12 03681
	Physicia	ın/	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day	3. Time of Death
	Medic Examin		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	January 19 2 4c. County	0/-
	Funeral	ì	202 22 6564 82	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year) 11–28–1929	9. Birthplace (State or Foreign Country)
(i)).	Director	ž	Usual Residence of Decedent	tion	11-28-1929	Ohio 10d. Inside City Limits
	Marylar 28a-f sh notified	Director	MD Talbot Easton			1 ☐ Yes 2 No
	with the s 23a or ust be r	Funeral D	10e. Street and Number 27488 Rest Circle	10f. Zip Code 21601	10g. Citizen of V	What Country?
036	s after death ral", or item Examiner m	by	1 Never Married 2 X Married 1 X Yes 2 No	s Decedent of Hispanic Origin? (Spes, specify Cuban, Mexican, Puerto	Rican, etc.) Blac	e - American Indian, ck, White, etc. White
21215-0036	is filed within 72 hours after death with the Maryland tal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 16a. Deceden (Give kin life. DO N Civil	nt's Usual Occupation d of work done during most of work NOT use retired) Engineer	kina	usiness/Industry District of elphia
	be filed w antal Hygi ked other c event, t	To Be	17. Father's Name (First, Middle, Last)	18. Mother's Nam	ne (First, Middle, Maiden Surname ae Oldfather	
Maryland	Schould be filed vin and Mental Hyg it is marked other traumatic event,		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing	Address (Street and Number or Rur Rest Circle Eas		State, Zip Code)
	permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic en		20a. Method of Disposition 20b. Place of Disposition	ion (Name of	Date 20c Location -	- City or Town, State
saltimore,	ermit. Page epartment c nportant: If ny injury or nce.			tory or other place) Cremation 1-21 Jame and Address of Facility LOWS, Helfenbein	n & Newnam Fune	ral Home, P.A.
m	<u>~~~</u>		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line.) S. Harrison St	Easton MD 21	Approximate Interval Between
إحتام	Ph _{sician/} Medical		Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	+	4	Onset and Death
	Examiner	er	Respir	stoy Coul	ve	
	rcuted and -transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):	~ ~		
09	tte be exe hysician a the burial	edical E		49		
Box 687	the Hospital or Attending Physician: The law requires that the death certificate be executed thin 24 hours after death. The Funeral Director: After this certificate has been signed by the attending physician and mpletely filled in by the funeral director, page 2 should be detached for use as the burial-transit.	Physician/Me		Ectopic pregnancy Other (specify)		te of delivery onth Day Year
. P.O.	s that the	þ	Part II. Other significant contributions contributing to death but not resolving in the did	erlying cause given in Part I.		ribute to the cause of death?
Vital Records,	w require s been s 2 should	Completed	desetes.		24a. Was an 24b. \	3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of
Rec	n: The la ificate ha or, page			26. Place of Death (Chec	performed?	death? 1 Yes 2 No
Vita	Physicia this cert al direct	To B	examiner? 1 Yes 2 Hospital: 1 Inpatient 2 ER/Outpatient	3 DOA Other: 4 Nursing H	ome 5 Residence 6 Othe	
Division of	tending F death. stor: After y the funer	Certificate:	27. Manner of Death 28a. Date of injury 28b. Time of injury 2	28c. Injury at work? M 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurre	ed
DIVISI	To the Hospital or Attending Physician: "Thin 24 hours after death as a feet death. To the Funeral Director: After this certific completely filled in by the funeral director,			, factory, office	28f. Location (Street and Number City or Town, State)	er or Rural Route Number,
	ne Hospi In 24 hou ne Funer pletely fill	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occ 2 Medical Examiner: On the basis of examination and/or investigation only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, death occ	ation, in my opinion, death occurred a	at the time, date and place, and due	e to the cause(s) and manner stated.
	To the within com	_	29b. Signature and kitle of certifier	29c. License number	29d. Date signed	d (Month, Day, Year)
ر د	4VA		30. Name and address of person who completed cause of death (Item 23a) (Type, Prin	D\$865656	Street Es	J-Can MJ 21601
J	Star Registra		31. Date filed (Month, Day, Year) 2 3 2012 Registrar's Signature B.	ball		

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician/ Month Joseph Henry Hubbert 29,2012 9:50 A M January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Federalsburg 408 Liberty Road Caroline If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Funeral 7. Age (In yrs. last birthday) 1 🔀 M 2 🗆 F 73 219-36-7277 **Director** Maryland Oct. 17, 1938 Usual Residence of Decedent l Hygiene. other than "natural", or items 23a or 28a-f shov ∞ant: the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Federalsburg Caroline MD 1 🗌 Yes 2 🗶 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21632 United States 408 Liberty Road 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or Nolf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 🙀 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 White 1 Yes 2 No Specify: Specify: 3 Widowed 4 Divorced '61-<u>63</u> Year or Dates. permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Tri-Gas & Oil Co. Fuel Truck Driver 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Sara Payne Edgar Joseph Hubbert 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 408 Liberty Road, Federalsburg, MD 21632 Margaret L. Hubbert/Spouse 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Feb. 3, 2012 Fastern Sh. Veterans Cem. Hurlock, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Framptom Funeral Home, P.A. Mishael Federalsburg, MD 21632 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph_sician/ al coneca disease or condition resulting in death) Medical **Examiner** sequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events Due to (or as a c Exami Hospital or Attending Physician: The law requires that the death certificate be executed and tran Due to (or as a consequence of): resulting in death) Last physician a s the burial-Physician/Medical Box 68760 attending p 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Year Yes 2 No ed by the a 9 Unknown 9 Unknown P.O. signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, HAN MIDDY 1 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown this certificate has been si ral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an death? 1 ☐ Yes 2 ☐ No Yes 2 No 25. Was case referred to medical examiner? Funeral Director: After this certific sted filled in by the funeral director, Be 26. Place of Death (Check only one) 2 No Hospital: Other: ၉ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 1 Natural 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury work?
1 Yes 2 No 5 Pending death. 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined 24 hours after City or Town, State) Medical 29a. Certifier 1 🛮 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Descripting Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) HO047522 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) John A-Apple TT
31. Date filed (Month, Day, Year) D. a. 3304 Has 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 20 | 2

		•	State	•	artment of Healt tificate of Deat			201	2 03583
			Registrar 1. Decedent's Name (First, Middle, Last)				2. Date of Deat		3. Time of Death
	Physicia Medic		PATRICIA	-	HARRIS		JANUAR	Y Day Yes	1012 2:00 PM
	Examin	er	4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Locat			4c. County of D	
7-4	Funeral		Prince George's Hospital Cent 5. Social Security Number 6. Sex 7. Age (In yr.	er s. last birthday)	If Under 1 Year If Un	rerly	8. Date of Birth	9.	George's Birthplace (State or Foreign
П	Director		578-58-0255 1 □ M 2 🔼 F 68	Yrs.	Months Days Hou	ırs Min.	Dec. 27,	, Year 943	^{Country} 1abama
	show at	or	Usual Residence of Decedent 10a. State 10b. County 10c.	City, Town or Lo	cation				10d. Inside City Limits
	Maryla 28a-f	Funeral Director	Maryland Prince George's		Capi	ital He	eights		1 🙀 Yes 2 □ No
	th the	al Di	10e. Street and Number		10f. Zip Code			log. Citizen of What	
	ath wit	uner	1011 Mentor Avenue 11. Marital Status 12. Was Decedent Ever in	118 113 1	20743 Vas Decedent of Hispanic		rify Yes or No-	United	States -
Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	1 Never Married 2 Married 3 Widowed 4 X Divorced Never Married 2 Married 1 Ves 2 No If Yes, Give Year or Dates.	lt lt	Yes, specify Cuban, Mex	xican, Puerto F	Rican, etc.)	Black, W Af	
5-0	"2 hou "natu	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give I	lent's Usual Occupation kind of work done during i	most of workir	ng	16b. Kind of Busine	ess Industry
12	rithin 7 iene. r than the M	Con	Elementary/Seconday (0-12) College (1-4 or 5+) 5+		ONOTuse retired) ninistrator/	/Manage	r	Self-E	mployed
pu	filed wall Hyg		17. Father's Name (First, Middle, Last)				(First, Middle, M	faiden Surname)	<u> </u>
ylaı	uld be Menta narked	T ₀	James Harris					Merritt	207/2
Mar	2 shouth and the and 27 is not traum.		19a. Informant's Name/Relationship (Type, Print) Sohna Millar – Daughter		ng Address (Street and Nu Mentor Aver	ımber or Rural 111e - Ca	Route Number,	City or Town, State, eights, M	zip Code) 20743 [aryland
ore,	of Hea of Hea fitem		20a. Method of Disposition 20th	o. Place of Dispo		Januai	-	20c. Location - City	
Baltimore,	ment ment tant: It iury or		1 ☐ Burial 2 🛱 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Lee's	Crematory	2	012		, Maryland
Ball	permit Depart Impor any in once		21. Signature of Funeral Service Licensee	had I	. Name and Address of Fa 4001 Benning				
			23a. Part 1. Enter the disease, or complications that caused the de						Approximate
	Physician.	(4 i)	shock, or heart failure. List only one caus, on each line. Immediate Cause (Final disease or condition	CARD	IAC AX	RHY-	THMI	4	Interval Between Onset and Death
	Medical Examiner	L	resulting in death) Due to (or as a consorting in death) Sequentially list conditions, b.	equence of):					
	uted Id ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events c.	eylderiče vij.					
	ate be executed physician and the burial-transit	alEx	resulting in death) Last Due to (or as a const	equence of):					
760	cate b physics the b	edical	d						
89 89	ath certific attending p	an/N	IF FEMALE: 23b. Was decedent pregnant is the post 12 months? 23c. If yes, outcome of pregnant 1 ☐ Live Birth 2 ☐ F		Ectopic pregnancy			23d. Date of	delivery
P.O. Box 687	the death by the att ached for	Physician/M	in the past 12 months? 1 Yes 2 No 9 Unknown 1 Unknown		Other (specify)			Month	Day Year
s, P.O	ires,that the dea signed by the a id be detached fi	by	Part II. Other significant conditions contributing to death but not	resulting in the u	nderlying cause given in F	Part I.			e to the cause of death? Probably 4 X Unknown
ord	v require s been si should b	olete					24a. Was ar		autopsy findings available
Rec	sician: The law is certificate has be lirector, page 2 s	Completed					autops perform	med? death	to completion of cause of n? Yes 2 No
ta	cian: ertific ector,	Be	25. Was case referred to medical examiner? Hospital:	,		Death (Check	only one)		
Ĭ.	Phys r this eral dir	e: To	1 Inpatient 2 27. Manner of Death 28a. Date of injury	28b. Time of	t 3 DOA Other: 4 D			ence 6 Other (Sp w injury occurred	pecify)
ono	anding sath. rr: Afte	ficate	1 X Natural 5 ☐ Pending (Month, Day, Year) 2 ☐ Accident ☐ Investigation	injury	work? M 1 ☐ Yes			··· ·· · · · · · · · · · · · · · · · ·	
Division of Vital Records,		Il Certificate:	3 Suicide 6 Could not be 4 Homicide determined 28e. Place of Injury - At building, etc. (Spec	home, farm, stre cify)	eet, factory, office	2	28f. Location (Sti City or Town		Rural Route Number,
	To the Hospita within 24 hours To the Funeral completed filled	Medical	29a. Certifier (Check 2 Medical Examiner: On the basis of examina	tion and/or invest	igation, in my opinion, deal	th occurred at	the time, date an	d place, and due to t	he cause(s) and manner stated.
	To the within To the comple	Σ	only one) 3 Certifying Nurse Practioner: To the best of 29b. Signature and title of certific	440	29c. License numb	per	2	9d. Date signed (Mo	
			· protu		D390	36		JANUARY	20, 2012
10	5		30. Name and address of person who completed cause of death (It	em 23a) (Type, P	D 390 M. ST; NW	in	LASHING	STON DO	20037
	Stat	e.	31. Date filed (Moath, Day, Year) 32. Registrar's Sig	ature	1. 01, 111	, ,		1	

erry Hunt 12-00379 UNK UNK

Physician Medical Examiner Physician The December's Name (First, Middle, Last) 2 Date of Death Date 2 Date of Death Date 3 December 3 D	JNK UNK	State of M 1- For State Registrar	aryland / Department o <i>Certificate o</i>			201	2 0269
Formation Compared to the part Compared	Physician/	Decedent's Name (First, Middle,Last)			2. Date of Death		3. Time of Death
Captol Heights Captol Heights Capto	Medical Examine	Perry Hunt			January 13	, 2012	0845 hrs
216-17-7812			and number)				
The first process of Possessers Total Unit Research Color Total Unit Research Colo			7. Age (In yrs. last birthday)			(MM/DD/YYYY) 9. Bir	thplace (State or
The street and Number	Director		_F 31 Yr		May 23	3,1980 Foreign	Mary Land
The Street and Authority The Authority The Street and Authority The Street and Authority The Authority The Street and Authority The Auth	Ágr		10c City Town or Loca	tion			40d Inside City Limite
## April 1 Martial State Applied To a part of the part	nd ice.	S.C.					1 Yes 2 No
## April 1 Martial State Applied To a part of the part	Aaryla 28a-f. 1 at ou Octo	10e. Street and Number		10f. Zip Code	100	g. Citizen of What Cou	
The specify Chain, Mestion, Participation (Chain) and Provided Toward (Chain) and Chain (Chain) and	h the 33 or sortified		rive	29707		U.S.A.	
Physician Microral Systems of the state of t	tems 2						ican Indian, Black,
Physician Microral Systems of the state of t	r, or in r. nu	3 Widowed 4 Divorced If Yes, G	ve Year	Yes 212 No specify:	,		ck
Physician Microral Systems of the state of t	natura Samir	15. Decedent's Education (Specify only higher	st grade completed) 16a. Deceder	nt's Usual Occupation (Give kind of w	ork done		
Physician Microral Systems of the state of t	36 in 72 h han "n lical E		ege (1-4 or 5+)	-			
Physician Microral Systems of the state of t	d with ygiene ther to M		ALCISC	<u> </u>			ur
Physician Microral Systems of the state of t	De file on the file of the fil			•		,	1.0
Physician Microral Systems of the state of t	Should and Me 7 is marke or To	19a Informant's Name/Relationship (Type, Prin La Vaida D. Hunt/Moth		g Address (Street and Number or R	tural Route Numbe	er, City or Town, State	
Physician Microral Systems of the state of t	e, M and 2 Health item 2		F				
Physician Microral Systems of the state of t	MOT Pages ent of nt: If				/2012	-	
Physician Microral Systems of the state of t	altii mit. J partm porta jury o	21. Signature of Funeral Service Licensee				DETESVII	ie,Mu.
Approximate Interviged Stammer Control of the Control of Control o			137	23 Bulloudins Ave	IV - P W/	asminoron i	C.20019
Sequentially list conditions, if any, leading to immediate ause. Enter Underlying Cause or Ingury tax institute oversits resulting in death) Last Total Contract of the Con		tallure. List only one cause on each line.	that caused the death. Do not enter t	he mode of dying, such as cardiac or	respiratory arrest	t, shock, or heart	Approximate Interval Between Onset and
The composition of the contribution of the c	Examiner	The state of the s					Death
Second S	<u>_</u>						
Second S	mine arine	cause. Enter Underlying Cause	r as a consequence of):				
Spanned and the second contribution of the sec	Exal	events resulting in death) Last Due to (c	r as a consequence of):				
The state of the s	executian and ial - tra						
The state of the s	760, cate be physici he buri		yes, outcome of pregnancy			23d. Date of delivery	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?	certifi certifi anding use as t	past 12 months?	Pregnant at time of death		icy		ay Year
The state of the s	Boy the attr ed for i	1 Vos 2 No 0 Ustra	3 L Oti	ner (Specify)		0	
The state of the s	that the red by detach	Part II. Other significant conditions contribu	ing to death but not resulting in the u	nderlying cause given in Part I.			
The state of the s	_ s _s s _			· · · · · · · · · · · · · · · · · · ·			
25. Was case referred to medical examiner? 1	COrc				autopsy	prior to co	
29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of pertifier 29c. License number 29d. Date signed (Month, Day, Year) January 14, 2012	I Re tificate or, pag	25. Was case referred to medical		26 Place of Death (Ohea)	1 ✓ Yes 2		2 No
29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of pertifier 29c. License number 29d. Date signed (Month, Day, Year) January 14, 2012	Vita ysicia his ce direct	examiner? Hospital:	Inpatient 2 ER/Outpatient			sidence 6 🗸 Other:	Scene
29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of pertifier 29c. License number 29d. Date signed (Month, Day, Year) January 14, 2012	ing Ph After tuneral funeral	27. Manner of Death 28a.	Month, Day Year)	njury 28c. Injury at Work?	28d. Describe how	v injury occurred	
29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of pertifier 29c. License number 29d. Date signed (Month, Day, Year) January 14, 2012	Sior Attend death. ector: by the i	2 Accident Investigation Jan	13, 2012 0831 hrs	1 165 2 140	oubject stabbe	ed and cut	
To be a certified by the cause of the cause	Divi	Suicide Social not be			or Town State	2)	
29b. Signature and title of gentifier 29c. License number 29d. Date signed (Month, Day, Year) January 14, 2012	0 - 4 >	20- 0-45					
29b. Signature and title of gentifier 29c. License number 29d. Date signed (Month, Day, Year) January 14, 2012	To the within comple	Medical Examiner: On the b	asis of examination and/or investigati	on, in my opinion, death occurred at	the time, date and	place, and due to the	cause(s)
11 Comercio	∑ ×				25	9d. Date signed (Mont	h, Day, Year)
/ I JU. Name and address of person who completed carise of death /Item 23a)	. 4	1/ Cluber	W)	O.C.M.E.	J	anuary 14, 2012	
Laron Locke MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223	211			Itimore Street, Baltimore, M	D 21223		
State 31. Date filed (Month, Day Year) 32. Registre 's Signature Registrar	State			,			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 4:30 A M Rosalee Hatcher 1/19/2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Ft. Washington Nursing & Prince George's Washington 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 M 2 XF Months Hours Min. (Month, Day, Year) 2-17-1922 Country) 89 NC **Director** 239-34-8347 Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD 1 X Yes 2 No Prince George's Ft. Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1303 Split Rock Lane 20744 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married þ 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: If Yes, Give 3₺ Widowed 4 □ Divorced Specify: Black Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry 2 should be filed within 72 h h and Mental Hygiene. 7 is marked other than "n (Specify only highest grade completed) Elementary/Seconday (0-12) 11th College (1-4 or 5+) Homemaker Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ t and 2 should b f Health and Mei tem 27 is mark Andrew Pope Lilia Hamilton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joanne Proctor/Daughter 1303 Split Rock Lane, Ft. Washington, MD 20744 permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other 1 or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State 1/30/2012 Suitland, MD 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Memorial 22. Name and Address of Facility Pope Funeral Homes, P.A. 21. Signature of Funeral Service MULO83 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition) <u>5538 Marlboro Pike, Forestville, MD 20747</u> Approximate Interval Between Onset and Death Ph_sician/ Acute Cerebrovascular Accident disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Atrial Fibrillation Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examine Due to (or as a consequence on) and I-transit Cancer of Cervix resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown P.O. signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? Yes 2X No 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 🔀 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes Certificate: 28d. Describe how injury occurred 5 Pending injury 2 🗆 No ☐ Accident☐ Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier 🙀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) 1-26-2012 D24535 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Laxmi Berwa, M.D. 7700 Old Branch Ave, Clinton, MD 20735

State Registrar 31. Date filed (Month, Pay Year) 2012

32. Registrar's Signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Jamison Month 4:30 PM Physician/ Margaret Januay Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore 20612 York Road Parkton If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Davs Hours 164-28-6230 88 Director 1 □ M 2 🕱 F Yrs. 28, 1923 MD Mar. or 28a-f show notified at 10d. Inside City Limits with the Maryland rector 10a. State 10c. City, Town or Location 1 Yes 2 X No Baltimore Parkton ā 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō ems 23a or Funeral 20612 York Road 21120 U.S.A. permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Inforctant: If item 27 is marked other than "natural", or items any rigury or other traumatic event, the Medical Examiner muones. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Race - American Indian, 11. Marital Status Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: Completed 3 ₩ Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Homemaker 11 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Anna L. Talbott Charles F. Turnbaugh 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lisa A. Dorn/Granddaughter|20612 York Road, Parkton, MD 21120 Date 4, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 2012 ☐ Donation 5 ☐ Other Specify Wiseburg Cem. White Hall, MD 21. Signature of Funeral Se 22. Name and Address of Facility JJ Hartenstein Mortuary, Inc New Freedom, PA 17349 24 N. Second St. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ENd - Stage Dementia Physician/ disease or condition Medical resulting in death) Due to (or as a comequence of) Examiner Sequentially list conditions, if any, leading to immediate the Enter Choonlying Examine Due to (or as a consequence of) nding physician and use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last the Hospital or Attending Physician; The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Pregnant at time of death the . 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Q 1 ☐ Yes 2 ☑ No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Yes 2 No <u>_</u> 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director; After completely filled in by the funer 1 Natural iniury 5 Pending Investigation Accident Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town. State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

15 M

2

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

N.S. RAJUPUKKIM.D.

FEB 0 9 2012

MSKajapahe M.D

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State

Registrar

2835 SmiMN 5203

DD057465

Bathmore MD 21209

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death . Decedent's Name (First, Middle, Last) 11: 45 P.M JANUARY Physician/ ISAAL JOHNSON Medical 4c. County of Deat 4a. Facility Name (if not institution, give street and number) 4b. City, Town **Examiner** FOIN HEALTH CARE If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Year) DEC 25, 1943 Days Months Hours NEW JERSEY 142-34-7764 68 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified any once. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 🔀 Yes 2 🗌 No NEW JERSEY SALEM PENNS GROVE 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number Funeral UNITED STATES 310 NORTH BOARD STREET, APT S9 08069 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12, Was Decedent Ever in U.S 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: BLACK Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) UNKNOWN UNKNOWN 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည STANLEY JOHNSON MILDRED BROKENBAUGH 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) YVONNE JOHNSON / WIFE 205 FLAGSTONE DRIVE, ANTIOCH, CALIFORNIA 94509 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3X Removal from State 4 ☐ Donation 5 ☐ Other (Specify) SALEM COUNTY VETERANS 01/27/12 WOODSTOWN, NJ 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final BAGWELL FUNERAL HOME NT 08069 PENNS GROVE. Approximate Interval Between Onsettand Peath Immediate Cause (Final STROKE Pnysician disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner PERTENSION Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examiner MELLITUS To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Other (specify) Pregnant at time of death been signed by t should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by PULMONAR STRUCTIVE 2 □ No 3 □ Probably 4 💆 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an cate has page 2 s autopsy performed death? 1 ☐ Yes 2 ☐ No certificate 25. Was case réferred to medical 26. Place of Death (Check only one) funeral director, Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 X No ည 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this 28c. Injury at work?
1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: injury Natural 5 Pending Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 🗓 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier

5+1VA

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HEALTH CARE SYSTEM, PERRY

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ JAN. 12:35A DEANNE DEANE JENNINGS Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner MONTGOMERY SUBURBAN HOSPITAL BETHESDA Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) 07/02/1938 Days Hours 513-36-0873 Director 73 1 M 2 N KS Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director 1 Yes 2 No MD MONTGOMERY BEALLSVILLE 10e. Street and Numbe 10f. Zip Code 9 10g. Citizen of What Country? 23a 19105 OLD PINE DRIVE 20839 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 No If Yes, Give ō þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No WHITE "natural", 3 Widowed 4 Divorced Specify: Year or Dates 12:35 Pm 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) HOUSEWIFE DOMESTIC 12 injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) WILLARD EUGENE SMITH THEDA JAMES F 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trau 01/24/2012 19105 OLD PINE DR., BEALLSVILLE, MD 20839 LISA JENNINGS/DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State MONOCACY CEMETERY 01/28/2012 BEALLSVILLE, MD 4 Donation 5 Other (Specify) 21. Signature of Furgeral Service Licenses 22. Name and Address of Facility P.O. BOX 86 HILTON FUNERAL HOME BARNESVILLE, DEANNE Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ HYPOXIA disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner HYPERCARBIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last PULMONARY HYPERTENSION 9万一八四日 Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Pregnant at time of death Month Day Year ed by the a P.O. signed It Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ OBESITY 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No HYPERTENSION 24a. Was an performed RHEUMATOID ARTHRITIS Hospital or Attending Physician: Division of Vital 25. Was case referred to medical director, 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Man / r of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of Certificate: 28d. Describe how injury occurred Natural 5 Pending work?
1 Yes 2 No of thours after death.

E Funeral Director; After the full of the 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 24 ho

To the Fune

completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Cartifying Number Practitioner: To the basis of my morning death occurred at the time, date and place, and due to the cause(ii) and manner stated. (Check 29b. Signature and title of certifi 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 01 KIMBERLY B. ZUZAK, MD 8600 OLD GEORGETOWN RD., BETHESDA, MD 20814

DHMH 17 Rev 06-2011

Registrar

32. Rer istrar's Signature

JAN 25

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 4:00 a^M 2012 Medical Examiner 4b. City, Town, or Location of Death 4c. County of Death LAUTONSUILCE MD REAMERY NAWKINS L MONTGOMERY 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 217-10-1592 **Director** 1 🗆 M 2 💢 F Tuly 3. MARYCAND or 28a-f show be notified at 10c. City, Town or Location 10d. Inside City Limits Director MONTGOMERY LAYTONSVILLE 10e. Street and Numbe 10g. Citizen of What Country? Hygiene. other than "natural", or items 23a or ent, the Medical Examiner must be r Funeral 7120 KAWKINS CREAMERY filed within 72 hours after death with 20882 USA 11. Marital Status 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Armed Forces?

1 Yes 2 No /-24-1 \square Never Married 2 \square Married ò Maryland 21215-0036 ☐ Yes 2 No Specify: GNITE 3 ₩idowed 4 ☐ Divorced Year or Dates: 10 /2 -//-Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry condary (0-12) College (1-4 or 5+) School School Cafeteria Worker should be filed with and Mental Hygien is marked other the permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ELMER MCKENZIE POORBAUGH MEKENZIE NELLIE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7120 Hawkins Creamery Rd, Laytonsville, MD 20882 Carol Murdock daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State MD Veterans Cemetery 1/27/2012 4 ☐ Donation 5 ☐ Other (Specify) Cumberland 21. Signature of Funeral Service License 21532 22. Name and Address of Facility Durst Funeral Home, 57 Frost Ave, frostburg, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** Years Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) the burial-transit Due to (or as a consequence of): resulting in death) Last attending physician Medical that the death certificate be Division of Vital Records, P.O. Box 68760 SB IF FEMALE use yes, outcome of pregnancy
Live Birth 2 Fetal death Physician/ 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) Live Birth 2 L retail do be detached for in the past 12 months?
1 Yes 2 No Month 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by • Hospital or Attending Physician: The law requires to 24 hours after death.
• Funeral Director: After this certificate has been sign. 2 No 3 ☐ Probably 4 ☐ Unknown To the Hospital or Attending Physician: The law requires within 24 hours after death.

To the Funeral Director: After this certificate has been six completely filled in by the funeral director, page 2 should 1 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform Senile dementia 1 Tes 2 No 25. Was case referred to medical examiner?

1 Yes 2 No 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA ည 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred 5 Pending Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 16809 30. Name and address of person who completed cause of death (Item 23a) Type, Print)

WILLIAM PARNES 18109 TRINCS DR (30, 1225) OLNEY, MD 20832 egistrar's Signature Registrar

			For State Registrar	State of Mary		Certificate of		entai i iy	Reg. No.	2012	03691
	Physici	an	1. Decedent's Name (First, Middle, La	st)				2. Date of Do		Year	3. Time of Death
16.	/Medic		Margaret Olet			T		JAN.		2012	3:30 P M
	Examir	ner	4a. Facility Name (If not institution, giv			4b. City, Town, o	r Location of Death			County of Death Carolir	
	Funeral	7.63	Envoy of Dente		yrs. last birtho	fay) If Under 1 Year	If Under 24 Hrs.	8. Date of Bi	irth	9. Birth	place (State or Foreign
12	Funeral Director		218-10-6312	1□ M 2□ X F	89 Yr	Months Days	Hours Min.	May	26, 19	Cor	ryland
	land Sw It		Usual Residence of Decedent 10a. State 10b. County	100	c. City, Town o	r Location					10d. Inside City Limits
	e Mary la-f sh tified a	ctor	MD Dorche	ester		Hur	lock				1 X Yes 2 □ No
	ath with the 23a or 28 ust be no	Funeral Director	10e. Street and Number 65 Legion Driv			10f. Zip Code	21643		Uni	ten of What Cou	ates
9036	be filed within 72 hours after death with the Maryland that Hygiene. ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed by Fune	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		13. Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 ☑ No	Specify:	ecify Yes or N Rican, etc.)			hite
5-	"natu edica	lete	15. Decedent's E (Specify only highest gra	ducation ade completed)	1 ((ecedent's Usual Occup Give kind of work done ife. DO NOT use retire	during most of worki	ng	16b. Kin	nd of Business/I	ndustry
12	withir ene. than he M	ш	Elementary/Secondary (0-12)	College (1-4or 5+)	Bak		u)		Hu	rlock	Bakery
d 2	i filed I Hygi other ent, t	Be C	17. Father's Name (First, Middle, Last	;)			18. Mother's Name	(First, Middle	e, Maiden S	Surname)	
/lan	Duld be 1 Mental arked or atic eve	To B	John W. Grena	adier			Margar	et Tr	anbe	rg	
Maryland 21215-0036	nd 2 shoulth and 27 is m		19a. Informant's Name/Relationship (Wayne Jones	(Type. Print)		Aailing Address (Street Box 941,					ip Code)
Baltimore,	m O		20a. Method of Disposition 1 Burial 2 Cremation 3			isposition (Name of crematory or other pla		Date		cation - City or	•
Ti m	nit. Pages artment of l ortant: If ite injury or o e,	Ш	4 Donation 5 Dother (Special	fy)	Unity-W	Mashington			1	ock, Ma	
Bal	permit. Page Department Important: If any Injury o		21. Signature of Funeral Service Lice	- CFSP		22. Name and Addre	ess of Facility Francurg, MD 2	mptom I 1632	Funera	al Home	, P.A.
,	Physician /Medical Examiner		23a. Part1. Enter the disease, or come shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	plications that caused the one cause on each line. a	ONAR	YFIBR		or respiratory	arrest,		Approximate Interval Between Onset and Death
	P #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as a co	nsequence of)	;					
	ecute and I-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as a co	nsequence of)	,					
68760,	eath certificate be executed attending physician and for use as the burial-transit	edical E		_ d		-					
			IF FEMALE:								
.O. Box	The law requires that the death cer tte has been signed by the attendir page 2 should be detached for use	Physician/N	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome pf p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death	3 ☐Ectopic pregnand 5 ☐ Other (specify) _	ey .		2	3d. Date of deli Month	very Day Year
Δ.	res that signed by be deta	by Ph	Part II. Other significant conditions	•	A	, ,	ven in Part I.	23e. Did	tobacco us	se contribute to	the cause of death?
ord	w require been sig should b	ted t	DIABETES, HX	PERTENSION	, ANE	MIS		1	Yes 2	No 3□Pr	obably 4 Unknown
Vital Records,	: The law r cate has be , page 2 sh	Completed	ATHEROSCULETTIL	CARDIOUASLI	4L4R	DISEASE		24a. Wa aut per 1□ Yes	opsy formed?		topsy findings available completion of cause of 2 No
/ita	Physiclan: The this certificate al director, page	Be C	25. Was case referred to medical examiner?			9	26. Place of Deat				
or/	Physic this c	户	1 ☐ Yes 2 No			allent 3 DOA	her: 4 Nursing Ho				cify)
ou c	ing After unel	ion:	27. Manner of Death 1	28a. Date of Injury (Month, Day Ye	<i>ear)</i> 28b. Tin Inju	ıry Wo	ıryat ırk?]Yes 2∐No	28d. Describe	e how injury	y occurred	
Division	deat deat ctor: y the	Certification:	2 Accident investigatio 3 Suicide 6 Could not b 4 Homicide determined	e 28e. Place of injury -	At home, farm	n, street, factory, office		28f. Location	(Street and	d Number or Ru	ıral Route Number,
Ö	는 et c	Certi	4 Hornicide	building, etc. (S	pecny)			City or 1	own, State)	,	
	To the Hospital of within 24 hours af To the Funeral Completely filled it	Medical (hysician: To the best of m miner: On the basis of exa and manner stated.	amination and/						
•	To th withir To th	Me	29b. Signature applittle of certifier	th ATTEND	116 M		05309	74	1 ~	e signed (Mont	17
V		-	30. Name and address of person who	completed cause of death	(Item 23a) (T	ype, Print)	ING DATE	AUE	FEDU	ealsb	ues, Mi
7	Sta Regist		31. Date filed (Month, Day, Year)	32. Registrar's	Signature	arke					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2012 Alice D. Kollinger 2:00A January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Talbot <u>Genesis He</u>alth Care-The Pines Easton If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number **Funeral** Country) VA 1 M 2 X F Months Days Hours Min. 6-Mosth, 19,23" 88 229-20-5867 Director Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f shot any injury or other traumatic event, the Medical Examinar must ha matter and 10d. Inside City Limits 10b. County 10a. State 10c. City, Town or Location Director 1 X Yes 2 No MD Talbot Easton 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 21601 USA 29430 Hawke's Hill Rd 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 11. Marital Status Black, White, etc. þ 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 X No Specify: Completed 3 X Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Deputy Clerk County Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Maude Barber Frank L. Davis Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Easton MD 21601 Federal Street Richard F. Kollinger (Son) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Eastern Shore
VA Cemetery 1 [X] Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1-23-2012 Hurlock, MD 22. Name and Address of Facility
Fellows, Helfenbein & Newnam Funeral Home, P.A.
200 S. Harrison St. Easton MD 21601 . Signature of Funeral Service Licensee 10175 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Doath Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence Examiner 16213 Sequentially list conditions, Physician/Medical Examine rany, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to ng physician and as the burial-transit MERN or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of by the attending physician Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) detached 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed Completed by should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an within 24 hours after death.

To the Funeral Director; After this certificate has completed filled in by the funeral director, page 2 sempleted filled in by the funeral director, page 2 sempleted filled in by the funeral director, page 2 sempleted filled in by the funeral director. autopsy 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 2 No 1 🗌 Yes မြ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No 5 Pending 1 Natural Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) To the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number

State Registrar 610

30. Name and address of person who completed cause of death (Jem 23a) (Type, Print)

Physician Diane Z. Kirsch Day Sept S. Syn S	rtment of Health and Mental Hygiene ificate of Death Reg. No. 2012 03692	_ roi	- 1
DIANE 2. KINSCH Security Security control processions by the reserve and number Security S	2. Date of Death 3. Time of Death	Decedent's Name (First, Middle, Last)	
Discolar Control of the Control of t	January 22 202 5:20HM		Medical
Discolar Discolar	Baltimore		Examiner
The street of the country The street of the country	Months Days Hours Min. (Month, Day, Year) Country) DA		Fulleral
10.1 20 BANNESVILLE ROAD 10.2 20.20 10.2 20.20 10.2 20.20 10.2 20.20 10.2 20.20 10.2 20.20 10.2 20.20 10.2 20.20 10.2 20.20 10.2 20.20 10.2 20.20 10.20 20.20 10.20 20			> I H
Continued and Continued and	1 ☐ Yes 2 ☑ No	MD MONTGOMERY BOYDS	r 28a-f notifie
Continued and Continued and	20041	16120 BARNESVILLE ROAD	s 23a c ust be
Continued and Continued and			er death or item niner n
Continued and Continued and	The state of the s	3 ☑ Widowed 4 ☐ Divorced If Yes, Give Year or Dates.	ours aft tural", al Exa
Continued and Continued and	nd of work done during most of working NOT use retired)	Specify only highest grade completed 16a. D	Z 1 O-
Continued and Continued and	0.1 12.10.12.1		ld 2.
Continued and Continued and			Nidall
Continued and Continued and		WAYNE CULLEN/SIGNIFICANT 16	d 2 sho d 2 sho salth and n 27 is r er traun
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, inflavour last only one cause on each line. Part Content and Dawle Content a	atory or other place)	20a. Method of Disposition 20b. Place of L	
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, inflavour last only one cause on each line. Part Content and Dawle Content a	Name and Address of Facility P.O. BOX 86		ermit. Pa epartme portani ny injury
Sequentially list conditions, infered Between Conset and Death Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a conseq		23a Part 1 Enter the disease or complications that caused the death Do not	
Due to (of as a consequence of): Part	Interval Between	shock, or heart failure. List only one cause on each line.	Ph sician/
The property of the property o			
d. FFEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3 Ectopic pregnancy 23d. Date of delivery Month Day Year 1 Yes 2 No 3 Probably 4 Unknown 23d. Indeed the constitution of death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24d. Was an autopsy performed 25. Was case referred to medical 25. Was case referred to medical 25. Was case referred to medical 25. Was case referred to medical 25. Was case referred to medical 25. Was case referred to medical 25. Was case referred to medical 25. Was case referred to medical 1 Yes 2 No 3 Probably 4 Unknown 25. Was case referred to medical 25. Was		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	2
The color of the		Cause (Disease or linjury that initiated events resulting in death) Last C. Due to (or as a consequence of)	execute in and ial-trans
autopsy performed to completion of cause death? 1		d	physicie the bur
autopsy performed to completion of cause death? 1	Ectopic pregnancy	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live Birth 2 ☐ Fetal death	ending r use as
autopsy performed to completion of cause death? 1	Other (specify) Month Day Year	1 Yes 2 No 4 Pregnant at time of death 9 Unknown	he death y the att ched fo hysici
autopsy performed to completion of cause death? 1			es that the signed be detailed by Pl
	24a. Was an 24b. Were autopsy findings available		w requires the second of the s
	performed2 death?		The lar
	011		ysician ysician s certif directol
	28c. Injury at work? 28d. Describe how injury occurred		ding Ph h. After thi funeral
	et, factory, office 28f. Location (Street and Number or Rural Route Number,	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined building, etc. (Specify)	r Attender ter death rector: by the ertific
	ccured at the time, date and place, and due to the cause(s) and manner as stated.		spital o hours af hours af neral Di filled in
	eath occurred at the time, date and place, and due to the cause(s) and manner as stated.		the Hothin 24 in the Fu
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Khadiia Duaw MD, Sinsi Hospital of Baltimer 2401 W. Belvedices Ave.		MAS M.D.	F > F &
	OF Baltimage 2401 W. Belvedires Ave.	30. Name and address of person who completed cause of death (Item 23a) (Ty	5
State Registrar 31. Date filed Month, Day, Year 1 AN 2 5 2012 32. Registrar's Signature Apartle Baltmone, MD Har	and Baltmore, MD 21215	31. Date filed Month, Day Year 32. Registrar's Signature 1.	State

		-	For State Of IVIS	Cer	tificate of D				0 02602
-	DI		1. Decedent's Name (First, Middle, Last)				2. Date of Death	Day Year	3. Time of Death
ш	Physicia Medic		Maxwell C.C. Kriendler				January	16 2012	5:56p ^M
-	Examin	er	4a. Facility Name (if not institution, give street and number)		4b. City, Town, or			4c. County of Death	
Secretary of	(1602 Berry Rose Court #3D 5. Social Security Number 6. Sex 7. Age	(In yrs. last birthday)	Fred If Under 1 Year	lerick If Under 24 Hrs.	8. Date of Birth		erick hplace (State or Foreign
	Funeral Director		000 20 2004		Months Days	Hours Min.	(Month, Day, Y	1958 Col	intry)
			Usual Residence of Decedent	33			Dec. 17,	- 1968 Nev	
	yland if sho ed at	tor	10a. State 10b. County	10c. City, Town or Loc	cation				10d. Inside City Limits
	e Mar r 28a- notifii		Maryland Frederick 10e. Street and Number	Frederic	k 10f. Zip Code		1.0	g. Citizen of What Co	1 Yes 2 X No
	ith th				217	Λ1	10	United St	
	ems arm	= 1	1602 Berry Rose Court # 3D 11. Marital Status 12. Was Decedent E	ver in U.S. 13. V	Vas Decedent of His f Yes, specify Cubar		ecify Yes or No-	14. Race - Amer	
9	er de or it		1 № Never Married 2 ☐ Married Armed Forces?	No			Rican, etc.)	Black, White	e, etc.
21215-0036	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at	Completed by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates.	1	Yes 2 🗓 No	Specify:		Specify: V	White
5-(72 hou "nat edica	l ple	15. Decedent's Education (Specify only highest grade completed)	(Give k	lent's Usual Occupa kind of work done di	ition uring most of work	ing 1	6b. Kind of Business/	Industry
12	ed within a Hygiene.	ပ္ပ	Elementary/Secondary (0-12) College (1-4 or 5-	+) /// /// // // // // // // // // // //	Nurses Nurses	Aide		Health	Care
73	the dyg	Be	17. Father's Name (First, Middle, Last)				e (First, Middle, Ma	iden Surname)	
/lan	ild be fill Mental narked o	임	Maxwell A. Kriendler			Margare	t Penisto	n Berk	
Maryland	should and N is ma		19a. Informant's Name/Relationship (Type, Print)	1				ity or Town, State, Zip	Code)
	of Health and Mental File of Health and Mental F fitem 27 is marked o r other traumatic eve		Henry A. Lowet /Executor					York 10103	
ore	je 1a it of H if ite or oth		20a. Method of Disposition 1 □ Burial 2 ☒ Cremation 3 □ Removal from State		natory or other place	9)		0c. Location - City or	
Baltimore,	it. Pag irtmer irtant njury		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature 15 neral Servic License 2					Frederick,	
Ba	permit. Page 1 a Department of P Important: If ite any injury or ot once.		21. Signature Prineral Service Liounce	N	tauffer F 621 Oposs	uneral H	omes P. A	lerick,Mar	yland 21702
			23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause of each line	the death. Do not ente	er the mode of dying	, such as cardiac o	or respiratory arrest	t,	Approximate Interval Between
_	trysician/		Immediate Cause (Final disease or condition	S, C, V	, D.				Onset and Death
	Medical Examiner		resulting in death) Due to (or as a	a consequence of):					
		er	Sequentially list conditions, if any, leading to immediate Due to (or as a	a consequence of):					
	ted 3 ansit	Examiner	cause. Enter Underlying Cause (Disease or injury						
	execu an and rial-tr		that initiated events resulting in death) Last C. Due to (or as a	a consequence of):		-			
092	icate be executed physician and is the burial-transit	edical	d						
687	rtifica ling pl		IF FEMALE:	of prognancy					
Box (ath certific attending 1 for use as	Physician/N	In the past 12 months?	2 🗌 Fetal death 3 🖺	Ectopic pregnanc	У		23d. Date of del Month	livery Day Year
W	he deg y the g iched	hysi	1 Yes 2 No 4 Pregnant at 9 Unknown						
P.0	requires that the des been signed by the s should be detached	by P	Part II. Other significant conditions contributing to death be	ut not resulting in the u	inderlying cause giv	en in Part I.	23e. Did toba	acco use contribute to	the cause of death?
ds,	quires en sig ould b	ted t	C.O.P.D	1 1			1 🗆 Yes	s 2 □ No 3 □ P	robably 4 Unknown
Records,	has ber ge 2 sho	Completed	Chronic Anticoac	Lulant	There	277	24a. Was an autopsy	prior to	topsy findings available completion of cause of
Re	sician: The lav certificate has lirector, page 2	Con		<u></u>			perform 1 Ves 2	ed? death? No 1 ☐ Yes	2 2 No
ta	ysician: is certifi director	Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital:		_ Othe	ace of Death (Chec			
of Vital	Phys r this eral di	일 ::	27. Manner of Death 28a. Date of injur		28c. Injury	at	ome 5 Resider 28d. Describe how	ice 6 Other (Spec r injury occurred	ify)
n C	ktending F death. ctor: After y the funer	icat	1 ☑ Natural 5 ☐ Pending (Month, Day 2 ☐ Accident Investigation	<i>(, Year)</i> injury	M 1 □	? Yes 2 ☐ No			
Division	I or Attend after death Director: /	Certificate:	3 Suicide 6 Could not be 28e. Place of Inju building, etc	ry - At home, farm, stre	eet, factory, office		28f. Location (Stre	eet and Number or Ru State)	ral Route Number,
Š	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi								
	Hospital	Medical	29a. Certifier 1 Decentifying Physician: To the best of (Check 2 Medical Examiner: On the basis of examiner:	xamination and/or invest	tigation, in my opinic	n, death occurred a	t the time, date and	place, and due to the	cause(s) and manner stated.
	To the Hosp within 24 ho To the Fune completely f	Σ	only one) 3 Certifying Nurse Practitioner: To the 29b. Signature and title of pertifier	best of my knowledge,	29c. License			d. Date signed (Monti	
	->-0		I Hall nD		10-	31912	_	01/18/2	UIZ,
	,		30. Name and address of person who completed cause of de	eath (Item 23a) (Type, F	Print)		A 1	1/	FNEDERILY
	10		JULIO MEDOCIAL MD		rub4m1	ANJ LON	e Sunt	1401	mD 3110
	Sta Registr		31. Date filed (Month) Pay Year 4 2012 32. Registra	ar's Signature	barrel				

							1 / -			1.1	1 6				
		4	For State	Sta	ite of M	aryland		artment <i>tificate</i>			and iv	lental Hy			
			Registrar 1. Decedent's Name	e (First, Middle, Last)				incate	01 0	Cutii		2. Date of Dea	ath 2	0 1	3. Time of Death
	Physicia Medic		Margaret	t Dorothy Kel	ler							Janua	ry 18	2012	2 0601 M
	Examin	er		not institution, give street ar	OSP, 70	d		4b. City, T	-	ston			4c. Cour	alb	of
	Funeral Director		5. Social Security No.	815 1□M 2		e (In yrs. Ia 73	st birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birt (Month, Day 9-12-1			thplace (State or Foreign nuntry) NY
p	how	'n	Usual Residence of 10a. State	of Decedent 10b. County		10c. City	, Town or Lo	cation							10d. Inside City Limits
Maryla	28a-f s	Director	MD	Talbot		Eas	ton								1 🏋 Yes 2 □ No
ith the	23a or 2		10e. Street and Nun 640 Mech	^{mber} klenburg Aven	ue Ar	ot 31:	3	10f. Zip					10g. Citizen o	of What Co	ountry?
eath w	tems a	Funeral	11. Marital Status	12. Wa	s Decedent I		13. \	Was Decede	ent of His	spanic Ori	igin? (Spe	cify Yes or No-			erican Indian,
21215-0036 within 72 hours after death with the Maryland	tal Hygiene. et other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by	1 ☐ Never Marr	ried 2 Married 1 If Y	Yes 2 X es, Give r or Dates.	No		Yes 2				, 110411, 010.,		lack, Whit	
15-C	"natu ledica	Completed	(Spe	15. Decedent's Education ecify only highest grade comp	oleted)		(Give	dent's Usual kind of work O NOT use	done d		t of worki	ng	16b. Kind of	Business	/Industry
212 within	giene. ner than t, the Me		Elementary/Second 12	ondary (0-12) Col	ege (1-4 or 5	5+)	Homen		reareay				Own 1	Home	
bul	tal Hyg	To Be	17. Father's Name (e (First, Middle,	Maiden Surna	me)	
Maryland 2 should be filed	and Mental is marked c aumatic eve		-	A. Meyers ame/Relationship (Type, Prin	t)		19h Mailir	na Address	(Street a			Darby I Route Numbe	er. City or Town	. State. Zi	ip Code)
	f Health and Meritem 27 is market other traumatic				son)	- 0		aksho				veland_			
Baltimore,	2 2 = 5			X Cremation 3 Remova	al from State	20b. Pl	ace of Dispo emetery, crer sapeal	sition (Nam natory or ot ke Cr é	e of her place 2ma t	lon		Date		-	r Town, State
oltim	Department Important: I any injury o		4 ☐ Donation	5 Other (Specify)	0.	1	Cen	ter_				-2012			lle, MD
å å	Departro Importa any inju		17.1	sent to to	me,	245	1 2	.00 S.	нат	riso	n St	<u>. Easto</u>	n MD Z	nera. 1601	Home, P.A.
			23a. Part 1. Enter t shock, or hea Immediate Cause (the disease, or complications art failure. List only one cause (Final	that caused on each line	d the death e.	n. Do not ente	er the mode	of dying	g, such as	cardiac c	r respiratory ar	rest,		Approximate Interval Between Onset and Death
	n, sician/ Medical		disease or condition resulting in death)	on a	Oue to (or	a consequ	en cof):	-	de	المال	<u> </u>	0. 1	0	111	
3.7	xaminer	er	Sequentially list co		Oue to (or as	a cartegu	ence of):	Lak		24-	V-C	tron	£0.22.	ble)	
nted	n and ial-transit	Examiner	cause. Enter Unde Cause (Disease or that initiated events	erlying finjury c	, i		<	Sep	S ₁ S	5 V	21/2	- Asp	mot p	hew	Drg.
be executed	, α ⊨	_	resulting in death)		ue to (or as	a consequ	ence of):	lee	d	,		,			
68760 ertificate b	ng phys as the	Medi	IF FEMALE:	d				4	•						
Box 68760 death certificate be	attending physicial for use as the bur	Physician/Medica	23b. Was decedent in the past 12 1 Yes 2	months?	es, outcome Live Birth Pregnant a	2 Feta	I death 3	Ectopic p		у				Date of de Month	elivery Day Year
		Phys	9 Unknown	ficant conditions contribution	Unknown	out not root	ilting in the I	and orbeing o	auco aix	en in Dorl		OSo Did t	abaasa uga sa	ntributo t	o the cause of death?
Records, P.O. The law requires that the	been signed by the attendin should be detached for use	ed by	Contraction of the significant o	177	ig to death t		arting in the	and onlying o							Probably 4 Unknown
COL	has bee	Completed		efaqu Vos	re &							24a. Was auto	psv	b. Were a prior to death?	utopsy findings available completion of cause of
I Re	certificate ha rector, page a		25. Was case referr	red to medical	ساس	~	•	-	26. Pla	ace of Dea	ath (Checi	1 Yes	ormed?	1 🗌 Ye	es 2 No
Vita	0 0	To Be		Hospital	1. Inpat		ER/Outpatie		Othe	er: 4 □ N	lursing Ho	me 5 Resi	dence 6 C	ther (Spe	cify)
n of	h. After ti funera	ate:	27. Manner of Deat 12 Natural	5 Pending	. Date of inju (Month, Da		28b. Time of injury	f 28	3c. Injury work		_	28d. Describe I	now injury occ	urred	
Division of Vital Records,	after death Director: A d in by the f	Certificate:	2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide	Investigation 6 Could not be determined	. Place of Inj building, et		me, farm, str)					28f. Location (nber or R	ural Route Number,
Division of Vital	within 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	Medical ((Check 2	Certifying Physician: T	the basis of e	examination	and/or inves	tigation, in n	ny opinic	on, death o	occurred a	t the time, date a	and place, and	due to the	cause(s) and manner stated.
To the t	within 2 To the F	Me	only one) 3	3 ☐ Certifying Nurse Pract	itioner: To th	ne best of m	ny knowledge	, death occu	rred at t	he time, da e number	ate and pla	ace, and due to	the cause(s) an 29d. Date sig	d manner	as stated.
•	,		▶ A	H. M.	0.		00 1 7	() × 9	265	624	5 -	Jam	J 10	7,2012
u	1		Austi	ress of person who complete	2780	, 240	i dir.	12 1	20	sly-	Cus	Street	f, EG	j←~	~ ND 2/60/.
	Sta Registr		J. Date filed (Mont	th, Day, Year) AN 23 2012	Registr	ar's Signat	. Sa	alle!		•					

			For Amend	ltem	27 State of Per me	vlarylan 924,	027EB	rtmen 72012	t of H	ealth a	and M	lental Hy	giene		22505
			Registrar 1. Decedent's Name (Fig. 1)	irst Middle I	ast)		Cer	tificate	OIL	eatri_		2. Date of De	Reg. No.	$\frac{2012}{2}$	3, Time of Death
	Physicia		Edward	A.	Lehman	n						Month Januar	Day	2012 Year	4:30a M
-	Medic Examin		4a. Facility Name (if not					4b. City,	Town, or	Location o	of Death	Januar		County of Dea	
J.	Examin	Ŭ.	Edenton Re	etireme	ent Center				Fred	erick	ζ			Frede	rick
	Funeral		5. Social Security Numb		. Sex 7. /	Age (In yrs. la	ast birthday)	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da			thplace (State or Foreign
6	Director		213-24-367		1 🔀 M 2 🗆 F	82	Yrs.	WIGHT	,-			Oct. 3			ryland
	nd how at	٦	Usual Residence of D 10a. State 10	b. County		10c. City	, Town or Lo	cation				oct. J	0, 12	/2) 11a	10d. Inside City Limits
	faryla Sa-f s tified	ect	Maryland	Frede	rick	Fr	ederio	· lz							1 ☐ Yes 2X No
	or 28	Funeral Director	10e. Street and Numbe		IICK	1 11	edelic	10f. Zip	Code				10g. Citi:	zen of What Co	ountry?
	s 23a ust b	era	7017 Arbon	Drive	2				21	703			Uni	ted St	ates
	death item	Fur	11. Marital Status		12. Was Deceder Armed Forces		3. 13.	Vas Decede	ent of His	spanic Orig	gin? (Spe	cify Yes or No- Rican, etc.)		14. Race - Ame Black, Whit	
36	72 hours after death with the Maryland "natural", or items 23a or 28a-f sho fedical Examiner must be notified at	d by	1 Never Married 3 Widowed 4		d 1 🔀 Yes 2 If Yes, Give	□ No		1 ☐ Yes 2						Cassifu	
21215-0036	atura cal E	Completed		5. Decedent's	Year or Dates	. WWII	16a Dece	dent's Usua	I Occupa	tion			16h Ki	nd of Business	hite
15	72 h an "n Medi	ldm		only highest	grade completed) College (1-4 of	. F. \	(Give	kind of worl O NOT use	k done di		t of worki	ng	TOD. KII	nd of Business	/IIIdustry
212	within giene. er thai		12	ary (U-12)	College (1-4 c	or 5+)		Mana	ager				Te1	ephone	Company
nd	filed al Hy d oth	Be	17, Father's Name (First	t, Middle, Las	st)	-				18. Mothe	er's Name	e (First, Middle,	Maiden S	Surname)	
yla	lld be Ment larke	오	Edward Ot	to Leh	nmann					Mary	Fer	iton			
Maryland	ge 1 and 2 should be filed within 72 hours after death with the Manyland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	124	19a. Informant's Name				1	_				l Route Numbe			
	and 2 s Health tem 27		Frances F.		nn/ Wife	l ook D	7017 lace of Dispo			ive,		erick,			
Baltimore,	nt of 1 nt of 1 t: If it		1 🖾 Burial 2 🗆 🤇	Oremation 3	Removal from Sta	ite C	emetery, crer	natory or of	ther place	1	1/18	/2012		cation - City or	
ţ	artme artme ortan injury		4 Donation 5			Res	thaver				dens				Maryland
Ba	permit. Page 1 and 2 st Department of Health a Important; If item 27 is any injury or other trae	1	re Dali	17	Minn	\wedge	Şi	auffe	er Fu	inera	1 Hc	mes P.	A.	ak Mal	and 21702
			23a. Part 1. Enter the o	disease, or co	omplications that cause on each	sed the death	n. Do not ente	er the mode	of dying	, such as	cardiac c	r respiratory ar	rest,	VD DW	Approximate
	Physician/		Immediate Cause (Fina disease or condition		2		22.27	-/			10	100	Y	DW	Interval Between Onset and Death
	Medical		resulting in death)	4		is a consequ		·~	- 1	\ /	10	0 0.	201 A	NV	
	Examiner	<u>.</u>	Sequentially list condit	ions,	0/	tured			//	100	1	1 July	25		
	sit d	nine	if any, reading to imme cause. Enter Underlyin	diate	Due to (or a	is a consequ	ichec o ji		1	MY	41	J. Mr			
	ecute and I-trans	Examiner	Cause (Disease or injuthat initiated events resulting in death) Last		c Due to (or a	as a consequ	ence of):				7 ×	720			
_	ite be executed hysician and the burial-transit	dical I					,				xla.	•			
120	icate y phys ss the	ledi			d										
687	eath certifica attending pl	N.	IF FEMALE: 23b. Was decedent pre	gnant	23c. If yes, outcom			Ectopic p					1 2	23d. Date of de	elivery
Вох	e atte	sicia	in the past 12 mor 1 ☐ Yes 2 ☐ N		1 ☐ Live Birt 4 ☐ Pregnan g ☐ Unknow	t at time of d		Other (sp		/				Month	Day Year
P.O. I	requires that the der been signed by the s should be detached	Physician/Me	9 Unknown									7		_	
9.	s tha igned be de	by	Part II. Other significan		_		-		ause give	en in Part i	I,				o the cause of death?
rds	een si een si oould	eted	12017-	11 130	n Di	5°-EC	75E					1 🗆	, "	1	Probably 4 Unknown
Records,	has b	Completed by										24a. Was auto		24b. Were at prior to death?	utopsy findings available completion of cause of
R	hysician: The lav nis certificate has I director, page 2		OF Was and a second to		1							1 Tes	2 No	1 🗆 Ye	s 2 No
of Vital	siciar certif irecto) Be	25. Was case referred to examiner? 1 Yes 2 □ N		Hospital:				Otha	ce of Deat					A == 1-1-1
of V	y Phy eral d	e: To	27. Manner of Death		28a. Date of in	njury	ER/Outpatier 28b. Time of		Bc. Injury	at		me 5 ∟ Resi 28d. Describe I		1	city) 1455 isted
nc On (nding ath. r: Afte	icat	2 X Accident	Pending Investigat		Day, Year)	injury	AM	work?	Yes 2	No	Fal)		173 121017
Division	r Atte er de recto by th	Certificate:	3 ☐ Suicide 6 4 ☐ Homicide	Could no determine	t be 28e. lace of	njury - At ho etc. (Specify)	me, farm, str	eet, factory,	, office			28f. Location (Street and	Number or Ru	ral Route Number
Ö	ital or urs aff ral Di	alC			Ed	enter	AL				1	FCERE	PICK	M	D
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	(Check 2 □	Medical Exa		f examination	and/or inves	tigation, in n	ny opinio	n, death oc	curred at	the time, date a	and place,	and due to the	cause(s) and manner stated.
	To the within 2 To the comple	Ž	only one) 3 LJ 29b. Signature and title	A	urse Practitioner: To	the best of m	ny knowledge		rred at the License		te and pla	ce, and due to		s) and manner a e signed (Mont	-
	FSFO		•	10-				772) 57		2		. 1	3/12	., ,
			30. Name and address	of person wh	o completed cause o	f death (Item	23a) (Type, F		21	7	,		1		2-1-04
	10x1		Hiren	1	oh mo	65		hon	760	5 1	hor	7500	By	200	21302
	Stat		31. Date filed (Month, D	av, Year)	32. Regis	strar's Signat	the same	arker							
	Registra	ar	· JF	M & 7	CUIC /Son	Bash	13. 19	65-67-0-							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Medical Month 5:30 AM LEWIS JOSEPH LEITHAUSER January 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Frederick Frederick Frederick Memorial Hospital If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) Social Security Number Age (In yrs. last birthday) **Funeral** Hours 1 🛛 M 2 🗆 F **Director** 219-18-6497 03/23/1927 84 Usual Residence of Decedent items 23a or 28a-f show her must be notified at 10d. Inside City Limits 10a. State 10c. City, Town or Location Director 1 X Yes 2 □ No Frederick MD Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21701 102 Mercer death v Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Examiner Armed Forces? Black, White, etc. 0 1 Never Married 2 Married ò Baltimore, Maryland 21215-0036 filed within 72 hours after 1 ☐ Yes 2 🎦 No If Yes Give Specify Year or Dates. WWII "natural", Completed 3 Widowed 4 Divorced White the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) d Mental Hygiene. marked other than College (1-4 or 5+) Elementary/Secondary (0-12) Federal Government 12 Civil Servant Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ္ and Ment Page 1 and 2 should be Theresa Krein Lewis Joseph Leithauser 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is any injury or other trau Shirlee Leithauser/wife 102 Mercer Ct. #211A, Frederick, MD 21701 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Stauffer Crematory 01/27/2012 Frederick, MD Signature of Funeral Service Licenses 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike, Frederick, MD 21702 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each ling. Opset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical r as a consequence of Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) use as the burial-tran and that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy for in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day Pregnant at time of death 5 Other (specify) signed by the at d be detached f 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by been signe should be 2 No 3 Probably 4 Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has autopsy perform within 24 hours after death.

To the Funeral Director, After this certificate to completely filled in by the funeral director, pag 1 Yes 2 25. Was case referred to medica 26. Place of Death (Check only one) To Be examiner? Hospital: 2 No Date of injury (Month, Day, Year) ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death Certificate: 28b. Time of 28d. Describe how injury occurred 28c. Injury at Natural iniury 5 Pending 1 Yes 2 🗌 No Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29c. License number 13 cause of death (Item 23a) (Type, Print) 0%

Registrar DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year,

IANO

mann

32. Registrar's Signature

			101	ryland / Department of Health and M	ental Hygiene
			State Registrar	Certificate of Death	Reg. No. 2012 03597
н	Physicia	n/	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year 70/4 70/7 20/6 M
	Medic	al	4a. Facility Name (if not ilistitution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
- Art	Examin		University of Mayyland Shows	K Truna Bultinove	
	Funeral Director		5. Social Security/Number 7. Age (197–38–2919 Usual Residence of Decedent	(h yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year) 1948 9. Birthplace (State or Foreign Country) Pennsylvania
	nyland I-f show ied at	ctor		10c. City, Town or Location Olney	10d. Inside City Limits 1 ☐ Yes 2 😿 No
	he Ma or 28a notif	Dire	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
	with t	Funeral Director	4325 Leeds Hall Drive	20832	United States
9800	within 72 hours after death with the Manyland grene. er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at	by	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Event Armed Forces? 1 ☑ Yes 2 □ N If Yes, Give Year or Dates.	er in 1967– 1967– In 1971	oify Yes or No- lican, etc.) 14. Race - American Indian, Black, White, etc. Specify: White
21215-0036	in 72 hou e. ian "natu Medical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	16a. Decedent's Usual Occupation (Give kind of work done during most of workin life, DO NOT use retired)	
21	d withi			1111000 001100110	
Maryland	ld be file Mental H arked ol a tic ever	To B	John Lopsonzski		
, Mar	d 2 shou alth and 1 27 is m er traum		19a. Informant's Name/Relationship (Type, Print) Susan Lopsonzski / Wife		
Baltimore,	Page 1 an nent of He nt: If Iten ry or oth		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	cemetery, crematory or other place) Norbeck Memorial 1/21	/12 Olnev, Maryland
Balti	To Father's Name (First, Middle, Last) John Lopsonzski 19a. Informant's Name/Relationship (Type, Print) Susan Lopsonzski / Wife 4325 Leeds Hall Drive, Olney, Maryland 20832 20a. Method of Disposition 18 Burial 2 Cremation 3 Removal from State A Donation 5 Other (Specify) 21. Signature of Funeral Service Loansee 22. Name and Address of Facility P. O. Box 5038, Laytonsville, Maryland 2088 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Last 15a. Informant's Name (First, Middle, Maiden Surmame) 15b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4325 Leeds Hall Drive, Olney, Maryland 20832 20b. Place of Disposition (Name of cemetery, crematory or other place) Norbeck Memorial 1/21/12 Olney, Maryland 20h. Signature of Funeral Service Loansee 22. Name and Address of Facility P. O. Box 5038, Laytonsville, Maryland 2088 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or conditions, if any, and first the invalidate Cause (Final disease or conditions) Sequentially list conditions, if any, and first the invalidate Cause (Final disease or conditions) Sequentially list conditions, if any, and first the invalidate Cause (Final disease) are consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):		riel M. Barbor Funeral Home aytonsville, Maryland 20882		
	Physician/	3 7	shock, or heart failure. List only one cause on each line. Immediate Cause (Final		respiratory arrest, Approximate Interval Between Onest and Death
ممعيد			resulting in death)		WD DWK
	ed sit	miner	Sequentially list conditions, It all, would go to for as a discusse. Enter Underlying Cause (Disease or injury)	conse vience di:	
	e execute cian and ourial-trar	al Exa	that initiated events C. —	consequence of):	(5 13
260	cate b physic		d	7.	
Box 687	To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending ply completely filled in by the funeral director, page 2 should be detached for use as t	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of 1 □ Live Birth 2 4 □ Pregnant at t 9 □ Unknown	Fetal death 3 Ectopic pregnancy	23d. Date of delivery Month Day Year
ls, P.O.	uires that th n signed by uld be detac	by	Part II. Other significant conditions contributing to death but	not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown
Division of Vital Records,	The law require ate has been si page 2 should I	Completed			24a. Was an autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 No 1 ☐ Yes 2 No
tal	ician: The certificate rector, pag	Be	25. Was case referred to medical examiner?	26. Place of Death (Check	only one)
Ξ	Physi this c	2	1 Yes 2 □ No Hospital: Inpatier 27. Manner of Death 28a, Date of Injury		me 5 Residence 6 Other (Specify)
o uc	ttending death. stor: After y the fune	icate	1 Natural 5 Pending (Month, Day, 2 Accident Investigation	Year) injury work? 2D A ADO M 1 □ Yes 2 No	Pike Assident
)ivisi	al or Attending s after death. I Director: After d in by the fune	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury building, etc.	v - At home, farm, street, factory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State) Headwaters Drive, Miney, MD
1	To the Hospital or Attending Physician: The la within 24 hours after death. To the Furneral Director: After this certificate he completely filled in by the funeral director, page	Medical	(Check 2 Medical Examiner: On the basis of exa	ny knowledge, death occurred at the time, date and place, an	d due to the cause(s) and manner as stated, the time, date and place, and due to the cause(s) and manner stated.
	To the within To the complete	2	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
			I Well up	> 215197	1/16/2012
	1241		30. Name and address of person who completed cause of dea	ath (Item 23e) (Type, Print) 22 South Greene St., I	Baltimore, Maryland 21201
I	Sta Registra		31. Date filed (Month, Day, Year) JAN 2 4 2012	B had I	

			7, 20c; nls	, Please	Type or	Prin	nt in Bl	ack Ir	ndelibl	e Ink	k. Ensi	ure A	II Copie	s A	re Leg	ible.	
	20/12, egany (State o	of Ma	aryland		artmen <i>tificate</i>			and M	1ental Hy	_	0.0	110	03608
	Physicia		1. Decedent's Name (Firs						imoure	01 2	- Cutiii		2. Date of De	Reg.		Vear	3. Time of Death
بهي تتاشيع	Medic	al	GLENN EDV 4a. Facility Name (If not in		LONG	ther)			4b City	Fown or	Location c	of Dooth	Month	_/	4c. County	a Olo	
مهيد	Examir		Western Ml	D Regi	onal Med	lica			Cur	nber.	land					1ega	iny
	Funeral Director		5. Social Security Number 236-50-238 Usual Residence of December 236-238	86	sex IXIM2□F	7. Age	(In yrs. last i		If Under Months	Days	If Under: Hours	Min.	8. Date of Bir (Month, Da 03/11/	ay, Yea	r) 1	Co	thplace (State or Foreign untry) st Virginia
	rland f show d at	tor	10a. State 10b	o. County			10c. City, To		cation								10d. Inside City Limits
	or 28a- notifie	Director	WV 10e. Street and Number	Minera	aT		Ke	yser	10f. Zip	Code				100	Citizen of \	Albat Co	1 Yes 2 No
	s 23a c nust be	Funeral	Route 2, 1	Box 22	5A					5726					U.S.A		untry?
980	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status 1 Never Married 2 3 Widowed 4		12. Was Dece Armed Fo 1 X Yes If Yes, Giv Year or Da	rces? 2 🗌 N e		11		fy Cubar	n, Mexican		cify Yes or No- Rican, etc.)			ck, White	rican Indian, e, etc. Vhite
15-0	72 hour "natur edical	Completed		. Decedent's E only highest gi			1	(Give F	lent's Usua kind of worl	k done di		of worki	ng	16b	. Kind of B	usiness/	Industry
212	within giene.		Elementary/Secondar 12	ry (0-12)	College (1	-4 or 5+	-)		O NOT use itract	,					Cons	truc	tion
Baltimore, Maryland 21215-0036	ld be filed Mental Hy larked oth atic event	To Be	17. Father's Name (First, Howard Ed Coward Ed	Middle, Last) dward	Long								y Stine		en Surname	9)	
, Mar	and 2 should I Health and Me tem 27 is marl ther traumati		19a. Informant's Name/F Beverley 1	Long /				Rot	ite 2,	Во			Route Numbe	WV	267	26	
imore	Page 1 a ment of H tant: If ite ury or oth		20a. Method of Disposition 1 Burial 2 □ Cr 4 □ Donation 5 □	remation 3		State	ceme	etery, crem Ashl	_	her place nete:	ry O	1/21) _{ate} /2012		Fort	Ash	Town, State Liby , WV -2675
Balt	permit. Depart Import any inj		21. Signature of Funeral	Servic Licer	See Lench	,,,	1	22	Name and	Addres Box	s of Facility	Upc Fo	hurch l rt Ashl	Fund	eral : WV	Home 2671	
			23a. Part 1. Enter the dis	isease, or com	plications that one cause on ea	aused t	the death. D										Approximate Interval Between
1	h sician/ Medical	i a	Immediate Cause (Final disease or condition resulting in death)		a. CAP	DU	consequence	ZKE	ST								Onset and Death
	Examiner						UALU Consequent			Di	SEAS	6					
	ed nsit	Examiner	Sequentially list condition in any, leading to immedicause. Enter Underlying Cause (Disease or injury	liate	Sue to (or as a	Consequent	ce of):	1								
	s executed ian and: urial-transit		that initiated events resulting in death) Last		C. Due to (or as a	consequenc	ce of):									
260	cate be physici s the bu	edica			d												
Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. within 24 hours after death. To the Funeral Director, After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the but the funeral director.		IF FEMALE: 23b. Was decedent pregr in the past 12 month 1 ☐ Yes 2 ☐ No g ☐ Unknown	hs?		Birth 2 nant at t	f pregnancy 	eath 3	Ectopic p Other (spe		У				23d. Dat		ivery Day Year
P.O.	is that th gned by be detac	by	Part II. Other significant	t conditions of	ontributing to de	eath bu	t not resultir	ng in the u	nderlying c	ause give	en in Part I						the cause of death?
Division of Vital Records,	require been si should	Completed											1 🗆 24a. Was				opsy findings available
Reco	The law ate has page 2	dwo:											auto	psy ormed	2 6	orior to d death?	completion of cause of
İta	certifica rector,	Be	25. Was case referred to examiner? 1 Yes 2 No		Hospital:					LOtho	ice of Deat	h (Check		-	11	Telesco I	
of V	ng Phys ter this neral di	te: To	27. Manner of Death		28a. Date			Outpatien Time of injury		A Injury work?	4 ∟ Nu at		me 5 Resident 18d. Describe l				f(y)
sion	uttendir death. stor: Af y the fu	Certificate:	2 ☐ Accident 3 ☐ Suicide 6 ☐	☐ Pending Investigatio ☐ Could not b	n De 28a Place		y - At home,		M M	1 🗆 ነ	Yes 2 🗌		29f Location //	Ctroot	-	or Or Pitt	nl Pouto Alumbar
Divi:	ital or A irs after al Direc lled in b		4 Homicide	determined	buildir	ıg, etc.	(Specify)						City or Tov	vn, Sta	ite)		al Route Number,
	e Hospi 24 hou e Funer detely fil	Medical	(Check 2 L M	/ledical Exam	sician: To the be iner: On the bas se Practitioner:	is of exa	amination an	d/or investi	igation, in m	ny opinior	n, death oc	curred at	the time, date a	and pla	ice, and due	to the c	ause(s) and manner stated.
	Vithir vithir comp		29b. Signature and title o	of certifier				nomougo,	29c.	License	number	o and pla	oo, and doc to		Date signed	(Month	, Day, Year)
	4+		30. Name and address of	+ '	ompleted caus		ath (Item 23:	a) (Type. P		12	287				1/18	3 12	
	NAS		C.H. Moor	re, M.1	D 125	500	Willo			id, (Cumbe	r1an	d, MD	215	502		
	Stat Registra	e	31. Date filed (Month, Day	y, Year) 2012	32. Re	egistrar'	's Signature	a Mad	1								

			For State		State o	of Maryla		artment of F		nd Me	ntal Hy	gien	e	LO	0266) ()
			Registrar 1. Decedent's Name (First,	Middle I as	et)		Cer	tificate of L	eath	12	Date of Dea	Reg. N	0. 7	12	U363	17
	Physicia		Gladys Mae	,	,					-	Month 1			ear	3. Time of Death 8:55 P	
11-4	Medic Examin		4a. Facility Name (if not ins			nber)		4b. City, Town, or	Location of	Death			c. County of		0.33 1	
	<u> </u>		Calvert Mar			lome		Rising					Ceci	1_		
	Funeral Director		5. Social Security Number 215–12–5862	<u>. </u>	ex □ M 2 🖾 F	7. Age (In yrs.	last birthday) 88 Yrs.	If Under 1 Year Months Days			Date of Birt (Month, Day 4 / 4 / 19		9	. Birthp Count	ace (State or Foreigny) DE	gn
	nd how at	ř	Usual Residence of Deceder 10a. State 10b. 0			10c. C	ity, Town or Lo	cation						10	d. Inside City Limit	ts
	Aaryla 8a-f s tified	Funeral Director	PA	Cheste	r	Co	chranvi	.11e							1 🗌 Yes 2 🔀 1	No
	the Na or 2	D	10e. Street and Number					10f. Zip Code				10g. C	itizen of Wha	t Coun	ry?	
	h with	ner	3575 Newarl	Road				19330				U	SA			
36	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f show t, the Medical Examiner must be notified at	by	11. Marital Status 1 Never Married 2		12. Was Dece Armed Fo 1 Yes If Yes, Giv	2 X No	l'	Vas Decedent of Hi f Yes, specify Cuba ☐ Yes 2 🙀 No	n, Mexican, F	n? (Specify Puerto Ric	Yes or No- an, etc.)		14. Race Black, \ Specify:	White, e	tc.	
21215-0036	ours a	Completed	3 🔀 Widowed 4 🗌 Di	vorced ecedent's E	Year or Da			lent's Usual Occup				1Ch :		Whi		_
215	יי איז רר an "n Medi	ldm		y highest gra	de completed) College (1		(Give I	kind of work done of NOT use retired)	duning most o	f working		100.	Kind of Busir	iess ma	ustry	
212	withir giene er tha t, the		7	J-12)	College (1	-4 Or 5+)	Avon	Products				M	lanufac	tur	ing	
Maryland	e filed ital Hy ed ott	To Be	17. Father's Name (First, M.							`	irst, Middle,					
Z	d Mer d Mer marke		Howard Pato		on a Dulmah						arboro			7: 0		_
Ma	12 shoulth an 27 is r traul		Dorothy J.		• • •	ighter		ig Address (Street a Cambridge						e, ZIP C	ode)	
	1 and of Hea item other		20a. Method of Disposition			20b.	Place of Dispo	sition (Name of		Date	T		Location - Cit	ty or To	vn, State	
m	Page nent c ant: If iry or		1 XBurial 2 ☐ Crer 4 ☐ Donation 5 ☐ C			State	**	natory or other place Cemetery		/30/3	2012	Por	t Depo	sit	• MD	
Baltimore,	permit. Page 1 and 2 should be filed within 72 hour: Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical once.		21. Signal of Funeral Se	rvice Licens	D Po	rdi.	22	. Name and Addres	s of Facility	R.T	. Foar	d F	uneral	Но	me, PA	
			23a. Part 1. Enter the dise shock, or heart failure	ase, or com	plications that one dayse on ea	caused the dea		er the mode of dying	g, such as ca	ırdiac or re					Approximate Interval Between	
-	Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)	. List only s	a. Del	menti (or as a consec		MZh	eime	21	141	26		V	Onset and Death	
A. A.	Examiner					(0. 40 4 00.1000	, 400.000							Т	`	
	_ +	iner	Sequentially list conditions in any, reading to immediate cause. Enter Underlying		Due to	(UF de a curica	puente ory:							-11		
	ecuted and transi	xam	Cause (Disease or iinjury that initiated events resulting in death) Last		C. Dua to	or as a consec	wience of					_		+		-
	ate be executed bhysician and the burial-transit	edical Examin	resulting in death) Last		Due to	(or as a consec	querice ory.									
760	icate t		1		d									1		
. Box 687	law requires that the death certific has been signed by the attending in pe 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregna in the past 12 months 1 ☐ Yes 2 No 9 ☐ Unknown	nt ?		Birth 2 ☐ Fer nant at time of	tal death 3 🗌	Ectopic pregnance Other (specify)	y				23d. Date o Month		ry Day Year	
s, P.O.	The law requires that the rate has been signed by the page 2 should be detach	þ	Part II. Other significant c	onditions o	ontributing to d	eath but not re	sulting in the u	nderlying cause giv	en in Part I,		23e. Did to		_	_	e cause of death?	wn
ord	w requ	Completed	4.	1							24a. Was a				sy findings availabl	
Rec	The ate	Som										rmed?	dea	th?	2 No	
tal	sician: The certificate rector, pag	Be	25. Was case referred to m examiner?	edical	Hospital:				ace of Death	(Check on		-				
fΝ	Physi this o	2	1 Yes No		28a. Date		ER/Outpatien	ot 3 DOA Othe	Nurs				6 Other (S	Specify)		
o u	th. Afer fulle	cate	1∕ Natural 5 □	Pending Investigation	(Mon	th, Day, Year)	injury	work	Yes 2□N	- 1	l. Describe h	ow inju	iry occurred			
Division of Vital Records,	or Atter	Certificate:	3 ∐ Suicide 6 ∐	Could not b determined	e 28e. Place	of Injury - At h	ome, farm, stre fy)	eet, factory, office		28f	Location (S City or Tow			r Rural :	Route Number,	
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director,	Medical	(Check 2 Me	dical Exami	ner: On the bas	sis of examination	on and/or invest	occured at the time, igation, in my opinio	n, death occu	irred at the	time, date a	nd plac	e, and due to	the cau	se(s) and manner sta	ated.
	To the within To th∉	2	29b. Signature and title of o			.5 the boat of H	.,oniougo, c	29c. License		piace, a			ate signed (//			
			Noel &	ha	0			Doors	2835	4		C	1125	12		
_	5		30. Name and address of p	erson who		01 Co.	DIAL	Way,	Pisin	a S	un, r	NI	219	ill		
	Stat Registra		31, Date filed (Month, Day, JAN 2	Year) 7 2012	Cent	legistrar's Sign	part far	w T			,					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JANUARY 4:42P MCVEY MARGARET LOUISE Medical 4a. Facility Name (if not institution, give street and number) 4h City Town or Location of Death 4c. County of Death Examiner FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK 5. Social Security Number 7. Age (In yrs, last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Days Hours Director 227-40-1909 1 🗌 M 2 🖷 Dec.6,1930 Virginia Usual Residence of Decede 81 r 28a-f show notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Director 1 Yes 2 No Frederick Maryland Frederick 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or dical Examiner must be Funeral 30 North Place 21701 within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 █ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Tes 2 No Specify: If Yes, Give Year or Dates Specify Completed 3 Widowed 4 Divorced White Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) י באסטון be filed within 72 uepartment of Health and Mental Hygiene. Important: If item 27 is marked other than "r any injury or other traumatic פוסכם. than " Elementary/Secondary (0-12) College (1-4 or 5+) 12 Care Provider Healthcare Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Isaac Harrison McCracken Hessie Greer McCracken 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy Browning, Daughter 25722 Ridge Road, Damascus, Maryland 20872 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 🚍 Burial 2 🗌 Cremation 3 🗖 Removal from State 4 Donation 5 Other (Specify) Gardens Jan. 28, 2012 Damascus, Virginia Sunset Mem. ■ Service Lio 21. Signatur 22. Name and Address of Facilit Molesworth-Williams, P.A., 26401 Ridge Road, Damascus оте 2<u>0872</u> Enter the disease, or complications that call death. Do not enter the mode of dying, such as cardiac or respiratory armst, Approximate shock or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final 06 COMPLICATION Physician/ COLONOSCOP disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner GASTROINT2STINAL MONTHS - 4EMS Sequentially list conditions Examiner Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying the burial-transit Cause (Disease or injury and that initiated events resulting in death) Last Due to (or as a consequence of) physiciar Physician/Medical death certificate be Records, P.O. Box 68760 as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ for in the past 12 months? Pregnant at time of death Month Yes 1 ☐ Yes ∠ ☐ 9 ☐ Unknown he Unknown or Attending Physician: The law requires that the by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed I Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy page perform 1 Yes 2 No Yes 2 No **Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 1 Tes 2 No ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completely filled in by the funer iniury ☐ Natural ☐ Accident 5 Pending -18-12 1 🗆 Yes 2 📈 No 4500 PM Investigation Secondary to C 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28f. Location (Street and Number or Run Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined FREDERICK Memorial Hospital 400 West 17th Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: Of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioper: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of 29d. Date signed (Month, Day, Year) 29c. License number

State Registrar 31. Date filed (Month,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

121

strar's Signature

State

Registrar

Box 68760

Division of Vital

A water

32. Registrar's Signature

death (Item 23a) (Type, Print)

,, 912 Seton Drive, Cumberland, MD

me and address of person who completed care of deat Thomas E. Chappell, M.D.,

31. Date filed (Month, Day

for State Registrar

29a. Certifier

Completed by Funeral Director

Be

ည

Physician/

Medical

Examiner

Funeral Director

28a-f show

Second Second North Second North Street Second North Sec	American Indian, White ness Industry e, Zip Code) at Birthplace (State or Foreign Country) 10d. Inside City Limits 1 Yes 2 No No American Indian, White
William Joseph Moody a. Facility Name (If not institution, give street and number) 86 Mount Pleasant Street Social Security Number 6. Sex 2	Death De
About Pleasant Street	Death B. Birthplace (State or Foreign Country) Maryland 10d. Inside City Limits 1 Yes 2 No at Country? American Indian, White hess Industry e, Zip Code) and 21532-
Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month), Day, Year) March 08, 1922 17-18-4772 10. County 10c. City, Town or Location 10b. County 10c. City, Town or Location 10b. County 10c. City, Town or Location 10c. City in 10c. City	American Indian, White ness Industry e, Zip Code) at Birthplace (State or Foreign Country) 10d. Inside City Limits 1 Yes 2 No No American Indian, White
Social Security Number 217-18-4772	American Indian, White e, Zip Code) at Country 21532-
Several Residence of Decedent 10b. County 10c. City, Town or Location 10f. Zip Code 10g. Citizen of What 10f. Zip Code 10g. Citizen of What 10f. Zip Code 10g. Citizen of What 10g. Citizen of Noricen 10g. Citizen of Noricen 10g. Citizen of Noricen 10g. Citizen of Noricen 10g. Citizen of Noricen 10g. Citizen of Noricen 10g. Citizen of Noricen 10g. Citizen of Noricen 10g. Citizen of Noricen 10g. Citizen of Noricen 10g. Citizen 10g. Citizen of Noricen 10g. Citizen 10g. Citizen of Noricen 10g. Citizen of Noricen 10g. Citizen t Country? American Indian, White etc. White e, Zip Code) 21532-	
10b. County 10c. City, Town or Location 10c. City, Town, State 10c. City, Town or Location 10c. City, Town, State 10c. City, Town or Location 10c. City, Town, State 10c. City or City or City	1 ☑ Yes 2 ☐ Notat Country? American Indian, White, etc. White ness Industry e, Zip Code) nd 21532-
Allegany Frostburg 10f. Zip Code 21532- 10g. Citizen of Whe U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1	1 ☑ Yes 2 ☐ Notat Country? American Indian, White, etc. White ness Industry e, Zip Code) nd 21532-
10f. Zip Code 21532- 10g. Citizen of What 10g. Citizen 10g. Citizen 10g. Citizen of What 10g. Citizen 10g. Citizen of What 10g. Citizen of What 10g. Citizen 10g. Citizen 10g. Citizen 10g. Citizen 10g. Citizen 10g. Citizen 10g. Citizen 10g. Citizen 10g. Citizen	American Indian, White, etc. White ness Industry e, Zip Code) ad 21532-
21532- U.S.A.	White etc. White ness Industry e, Zip Code) ad 21532-
Armed Force? 1 Never Married 2 Married 1 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 3 Never Married 2 Never Married 2 Never Married 2 Never Married 3 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 3 New Mode 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired)	White etc. White ness Industry e, Zip Code) ad 21532-
1 Yes 2 No No No No No No No	white ness Industry e, Zip Code) nd 21532-
16a. Decedent's Usual Occupation (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. Do NOT use retired) 16b. Kind of Busin (Give kind of work done during most of working life. Do NOT use retired) 17church 18. Mother's Name (First, Middle, Maiden Surname) 18. Mother's Name (First, Middle, Maiden	e, Zip Code) ad 21532-
College (1-4 or 5+) Church	e, <i>Zip</i> Code) nd 21532-
Parish Priest 12 4 Parish Priest 18. Mother's Name (First, Middle, Last) William Moody 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State Mary Moody a. Method of Disposition 1	nd 21532-
Sal. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.	nd 21532-
William Moody Ba. Informant's Name/Relationship (Type, Print) Mary Moody sister 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State 86 Mount Pleasant Street Frostburg Marylan a. Method of Disposition 1	nd 21532-
Mary Moody sister 86 Mount Pleasant Street Frostburg Maryland a. Method of Disposition 1	nd 21532-
a. Method of Disposition 1	
1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Saint Michael's Cemetery Saint Michael's Cemetery 1/19/2012 Frostburg 22. Name and Address of Facility Durst Funeral Home, 57 Frost Ave., Frostburg, M 3a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.	ty or Town, State
Saint Michael's Cemetery 1/19/2012 Frostburg 1. Signature of Fundal Service Licensee 22. Name and Address of Facility Durst Funeral Home, 57 Frost Ave., Frostburg, M 3a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.	
Ba. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.	Maryland
3a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.	ID 01520
shock, or heart failure. List only one cause on each line.	
mmediate Cause (Final	Approximate Interval Between
inmediate Cause (Final issease or condition issulting in death) a. Atherosclerotic condition death)	Onset and Death
Due to (or as a consequence of):	
equentially list conditions, any, leading to immediate b. Due to (or as a consequence of):	
ause. Enter Underlying ause (Disease or linjury	
at initiated events C. Due to (or as a consequence of):	
FEMALE: 3b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3 Ectopic pregnancy	of delivery
in the past 12 months? 1 Yes 2 No 9 Unknown Month	Day Year
9 Li Unknown	
urt II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contributions.	`
1 \(\text{Yes} \) 2 \(\text{No} \) 3	Probably 4 Unknown
24a. Was an autopsy prio	re autopsy findings available or to completion of cause of
performed? dea	ith? ☐ Yes 2 /X No
. Was case referred to medical examiner? 26. Place of Death (Check only one)	
1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (S	
. Manner of Death 1 Natural 5 □ Pending 28a. Date of injury (Month, Day, Year) 28b. Time of injury 28c. Injury at work? 28d. Describe how injury occurred	Specify)
2 Accident Investigation M 1 Yes 2 No	Specify)

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760

Medical

Examiner

Physician/Medical

To Be Completed by

Medical Certificate:

State Registrar

00055325

1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Jan 17, 20/2

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Bishop Walsh Cumberland MD 21502

WONSOIC 5HIN 31. Date filed (Month, Day, Year) JAN 18 2012 925 MO 32. Registrar's Signature

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 2 . Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician/ Rose Lee Mooney Kinuan Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Washington County Meritus Medical Center Hagerstown Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, 7. Age (In vrs. last birthday) **Funeral** Min. 233-78-0732
Usual Residence of Decede **Director** 1 🗆 M 2 💢 F 65 Nov. 5,1946 West Virginia show 10a, State notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 28a-f Maryland | Washington Co. Hagerstown 1X Yes 2 ☐ No 10e. Street and Number rms 23a or rmust be r 9 10f. Zip Code 10g. Citizen of What Country? Funeral 219 Division Avenue 21740 USA items be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, the Medical Examiner Black, White, etc. ō þ 1 Never Married 2XXMarried Yes 2 X XNo Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify Specify: Black "natural", Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Personal Residence Homemaker traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ permit. Page 1 and 2 should be Department of Health and Ment. Important: If item 27 is marked any injury or a second seco Luella Mickens Charles L. Fugate 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles Lee Mooney/ Husband 219 Division Ave. Hagerstown, Maryland21740 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2X Cremation 3 Removal from State Smithsburg Crematory! Jan. 30,2012 Smithsburg, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Douglas A. Fiery Funeral Home Eastern Blvd. N., Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause greach line. Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine burial-transi and resulting in death) Last anding physician are use as the burial Physician/Medical The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ ģ ☐ Pregnant at time of death☐ Unknown detached 9 Unknown P.O. signed by i Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 No 3 □ Probably 4 □ Unknown Division of Vital Records, 1 🗌 Yes Completed should peen Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy certificate Yes 2 No 1 Yes 2 No To the Hospital or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, this 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred eral Director: After filled in by the funer Natural 5 Pending work? 1 ☐ Yes 2 ☐ No hours after death Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the F 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) ess of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

IW-

Medical

11116

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene #30 Registrar MD, TCHD, phayers 1/23/Qextificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ January 0115 012 Carroll F. Morgan Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Talbot Easton Memorial Hospital 8. Date of Birth (Month, Day, Year) 8–12–1923 9. Birthplace (State or Foreign If Under Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours 88 MD 218-16-7229 1 X M 2 □ F **Director** Usual Residence of Decedent 10d. Inside City Limits 10c, City, Town or Location 10b. County 10a. State with the Maryland Director 1 X Yes 2 No 28a-f Easton Talbot MD 10g. Citizen of What Country? 10f. Zip Code ō 10e, Street and Number 23a USA 21601 640 Mecklenburg Ave. Apt 113 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) other than "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married þ within 72 hours after 21215-0036 White If Yes, Give Year or Dates 1 Yes 2 X No Specify Specify 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Automotive 11 Salesman Be 18. Mother's Name (First, Middle, Maiden Surname) Maryland should be filed 17. Father's Name (First, Middle, Last) Carrie Estelle Carroll Martin Ford Morgan or other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 640 Mecklenburg Ave. Apt 113 Easton MD 21601 (wife) Beatrice A. Morgan Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition permit. Page 1.
Department of I
Important: If it
any injury or or cemetery, crematory or other place)
Chesapeake Cremation
Center 1 Burial 2 XCremation 3 Removal from State 1-20-2012 Stevensville, MD 4 Donation 5 Other (Specify) 22 Name and Address of Facility Fellows, Helfenbein & Newnam Funeral Home, P.A. 200 S. Harrison St. Easton MD 21601 Signature of Funeral Service Licensee JOHN R MERCERON 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Acup Physician/ Myrra! disease or condition resulting in death) Medical Examiner Sequentially list conditions. Examiner Due to (or as a dur sequence or) it any, leading to immediate cause. Enter Underlying Cause (Disease or injury or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Day 1 Yes 2 Unknown q Linknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ obstructive 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b Were autopsy findings available prior to completion of cause of death? 24a Was an has performed? Yes 2 No 1 Yes 2 No this certificate 25. Was case referred to medica examiner? funeral director, 26. Place of Death (Check only one) Be Other: Hospital 1 Yes 2 No 4 Nursing Home 5 Residence 6 Other (Specify) ျှ 1 Inpatient 2 ER/Outpatient 3 DOA Manner of eath 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: after death. Director: After 1 Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be 3 Suicide 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical

within 24 hours a Hospital

> 31. Date filed (Month, Day, Year) State Registrar

only one

29b. Signature and title of certifie

Ludwig

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Eglseder III.

503

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Cynwood Drive, Easton,

29d. Date signed (Month, Day, Year)

Md

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ January Ellen Miller Alberta 2012 0310 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Caroline Nursing Home Caroline If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign Funeral Days Hours July 23 1 M 2 X Maryland Director 236-24-7733 88 Usual Residence of Decedent show 10b. County 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Caroline Maryland Greensboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 25952 Pinetree Lane 21639 U.S.A. Page 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates White 3 XWidowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. I o**ther tha**n " Elementary/Seconday (0-12) College (1-4 or 5+) Garment Factory 11 Seamstress Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F is marked o မ Thomas H. Ellifritz Ethel E. Johnston 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health are Important: If item 27 is any injury or other trau John H. Wall 25952 Pinetree Lane; Greensboro, MD 21639 Saltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Meadow Point Cemetery Jan 28 2012 Keyser, West VA 22. Name and Address of Facility PO Box 160; Greensboro, MD 21639 Signature of Funeral Service Licenses Fleegle and Helfenbein Funeral Home, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Dementi Physician/ agranced disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or iinjury this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical or Attending Physician: The law requires that the death certificate be after death. Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Pregnant at time of death g Unknown q I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe 1 Yes 2 No 2 N 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: Other: 1 Tyes ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27, Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred neral Director: After filled in by the funer Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number determined Hospital within 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

JAN 26 201

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3683

32. Registrar's Signature

DHMH 17 Rev 7/2009

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

D0053256

Preston mo 21655

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Physician/ Janice W. Moore January 21,2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Chesapeake Woods Center-Genesis Elder. Cambridge Dorchester If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) Funeral Days Hours 1 M 2 D 91 Yrs Director 220-03-5162 May 12, 1920 Maryland Usual Residence of Decedent r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Dorchester MD Hurlock 1 Yes 2 No 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 110 Dogwood Drive 21643 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 If Yes Give 1 ☐ Yes 2 No Specify: White Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) filed within 72 If Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Warwick Corporation Bookkeeper 11-Graduate 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Julius W. Wheatley Nellie Bowman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joyce A. Spratt/Daughter 110 Dogwood Dr., Hurlock, MD 21643 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dorchester Memorial Park 01/24/12 Cambridge, Maryland 22. Name and Address of Facility Framptom Funeral Home 21. Signature of Funeral Service Licensee CFSP 216 N. Main St., Federalsburg, MD 21632 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ CONGESTIVE HEART 4 EARS disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner HYPERTENSION YGARS Sequentially list conditions, If any, leading to immediate cause. Enter Underlying Exami Cause (Disease or iinjury that initiated events death certificate be executed and-tran Due to (or as a consequence of): resulting in death) Last physician a the burial-Physician/Medical Box 68760 attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Month the 9 Unknown 9 Unknown P.O. ò Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by RENAL INSUFFICIENCY 1 Yes 2 No 3 Probably 4 Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe 1 Yes 2 No Yes 2 No Hospital or Attending Physician: 24 hours after death. of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 1 No 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending Division 1 ☐ Yes 2 ☐ No 2 Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 2 To the I 29b. Signature and title of certifier D0070752 2012 Kn

State Registrar

DHMH 17 Rev 7/2009

503 BYRN STREET, CAMBRIDGE, MD 21613

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

. Registrar's Signature

MOFFATT

ROHAN

			For State	State of M	larylan	-	artment <i>tificate</i>			and Me			201	2 03	2707	
			Registrar 1. Decedent's Name (First, Middle, Las	2. Date of Death					Reg. No. ath	<u> </u>	3. Time	of Death				
	Physicia Medio		Idora Maria	McKelvin	n						Janaury 18, 2012			9:05		
	Examin		4a. Facility Name (if not institution, give	4b. City, T	own, or	Location o	of Death		4c. (County of Dea						
-4			6267 Maxwell D		Camp Springs					Prince George's						
	Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)					If Under 1 Year If Under 24 Hrs. 8. Date of Birt Months Days Hours Min. June 29					9. Birthplace (State or Fo.			0	
	Director		577-68-4142 Usual Residence of Decedent		61	Yrs.				μυ	ine 29	, 193	50	DC DC		
	show at	5	10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10d. Inside	City Limits	
	Aaryla 8a-f tified	ect	Maryland Prince G	eorge's					Camp	Sprin	ngs			1 🖾 Ye	es 2 🗆 No	
	the l	۵	10e. Street and Number				10f. Zip (Code				10g. Citiz	en of What C	ountry?		
	s 23a	Funeral Director	6267 Maxwell 1	Orive				2	0746			Uni	ted St	ates		
	death item ner n	교	11. Marital Status	12. Was Decedent Armed Forces?		S. 13. V	Was Decede f Yes, specif	nt of His	spanic Orig	gin? (Specify , Puerto Ric	Yes or No- an, etc.)	1	4. Race - Am Black, Whi	erican Indian,		
36	after II", or xami	d by	1 A Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 If Yes, Give	No	i	Yes 2					s		lack		
21215-0036	atura cal E	Completed	15. Decedent's E	Year or Dates.	-	16a. Deced	ent's Usual	Occupa	ation			16b Kin	d of Business			
215	an "n Medi	m Id	(Specify only highest gr		5.1	(Give	kind of work O NOT use i	done d		of working	Î	TOD, KIII	d Or Dusiness	s industry		
212	withir giene er th , the		Elementary/Seconday (0-12)	College (1-4 of	5+)	Data	a Entr	y S	pecia	list			Gover	nment		
pu	filed tal Hy d oth	o Be	17. Father's Name (First, Middle, Last)						18. Mothe	er's Name <i>(F</i>	irst, Middle, i	Maiden Si	urname)			
yla	Ild be Ment arke	은	John Hen	ry McKelvi	in Sr	•			C	ra Ma						
Maryland	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mertal Hygiene. if health and Mertal Hygiene, items 23a or 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationship (7	,		1						-			00770	
e,	and 2 Health em 2 ther 1		Brandy M. Boone -	Daughter	20h E	591/ Place of Dispo								/	20770	
nor	age 1 int of t: If it		1 🔀 Burial 2 🗆 Cremation 3 🗆			cemetery, cren	natory or oth	ner place	e) Ja	anuary			•			
Baltimore,	permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other trai	1.3	4 ☐ Donation 5 ☐ Other (Special 21. Signature of Funeral Service License			Harm		Addres	s of Facility	201				, Maryl e, Inc.		
Ba	Depar Depar Impor any in	1	John 7	Stewo	wt, =	2					Wash:			20019		
			23a. Part 1. Enter the disease, or com shock, or heart failure. List only o	plications that cause	d the deat		_							Approxim		
	hysician/	5 5	Immediate Cause (Final disease or condition			ic Line	searco	ma						Interval Be Onset and		
	Medical	resulting in death) Due to (or as a consequence of):									-					
	Examiner	<u>.</u>	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying b. — Due to (or as a consequence of):													
		Examiner														
	ecute and I-trans	Exar	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as	a consequ	uence of):										
0	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rail director, page 2 should be detached for use as the burial-transit	dical		La										1		
290	icate g phys	ledi		d								_				
89	eath certificat attending ph I for use as th	N/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			Ectopic pr	200000				2	3d. Date of d	elivery		
Box 687	death ie atte ed for	sicie	in the past 12 months? 1 ☐ Yes 2 🎛 No	4 Pregnant			Other (spe		у				Month	Day	Year	
P.O. I	t the dea by the a tached	Physician/Me	9 Unknown			Mr. J. M.	1.1.									
σ.	v requires that is been signed be should be deta	ğ	Part II. Other significant conditions of	ontributing to death	out not res	suiting in the u	nderlying ca	iuse giv	en in Part I					o the cause of		
rds	equire een s nould	eted									1 1 1	res 2∟		Probably 4 🛭		
Records,	law r has b e 2 sl	Completed									24a. Was a autop		24b. Were a prior to death?	utopsy findings completion of	s available cause of	
R	iician: The la certificate ha rector, page		05 \\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\						<u> </u>		1 🗌 Yes			es 2 🗆 No		
ital	sician certif recto	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ♣No	Hospital:				Otho		h (Check on	,,		_			
of Vital	Phys r this ral dii	일 ::	27. Manner of Death	28a. Date of inj	ury	ER/Outpatier 28b. Time of		c. Injury	4 ∐ Nu		5 A Resid		Other (Spe	cify)		
n c	nding F ath. ; After e funer	icat	1 X Natural 5 ☐ Pending 2 ☐ Accident Investigation	(Month, Da	y, Year)	injury	M	work'				o				
Division	I or Attendi after death. Director: A I in by the fu	Certificate:	3 Suicide 6 Could not be 4 Homicide determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)							28f			Number or R	ural Route Nun	nber,	
Ω̈́	ital or ins aft ins Dir led in			1;							City or Tow	,				
	To the Hospital or Attending within 24 hours after death. To the Funeral Director. After completed filled in by the fune	Medical	29a. Certifier 1 Certifying Phy (Check 2 Medical Exam	iner: On the basis of	examinatio	n and/or invest	tigation, in m	y opinio	n, death oc	curred at the	e time, date ar	nd place, a	and due to the	cause(s) and n	nanner stated.	
	To the I within 2 To the I comple	ž	only one) 3 Certifying Nur 29b. Signature and title of certifier	se Practioner: To the	best of m	y knowledge, o	death occum	ed at the	number	and place, a	and due to the	e cause(s)	and manner a	s stated.		
	ĭ > 1° °°		> Jocelyne 10	countche	ou,	MD			748	,			signed (Mon	, 2012		
			30. Name and address of person who						-, 0			Jana	ZJ	,		
R	3		Jocelyne Koucel			wder Mi		ad	Calv	erton	, Mary	land	2070	5		
	Sta Registr		31. Data filed (Month, Day, Year) JAN 2 5 2012	"32. Registi	o's Signa	pire in the	-									

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 101-23-2012 BEATRICE MANLEY 8:45p M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 1000 Brightseat Road Lanodver Prince Georges Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country)
VA 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days Hours Min Martin 1973771921 Director 577-32-7288 Usual Residence of Decedent show should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a.4 show 10b. County ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10a State 10c. City, Town or Location 10d. Inside City Limits Director MD Prince Georges Landover 1 ¥ Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1000 Brightseat Road 20785 USA 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Force Black, White, etc. by 1 Yes 2 No
If Yes, Give
Year or Dates. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Black 1 ☐ Yes 2 XNo Specify: Completed 3 X Widowed 4 ☐ Divorced Specify 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12th Housewife Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Department of Health and Ments Important: If Item 27 is marva any injury or a second Charles Williams Pearl Scott 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 1000 Brightseat Rd #159 Landover, MD 20785 Ruth J. Davis Rollins Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗀 Removal from State Ft Lincoln Cemetery 1/28/2012 4 ☐ Donation 5 ☐ Other (Specify) Brentwood, MD Signature of Funeral Service 22. Name and Address of Facility Bianchi 814 Upshur St NW Wash, DC 20011 23a. Part 1. Enter the disease, a complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death Immediate Cause (Final Physician disease or condition ena sease ears Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Day Year Pregnant at time of death Unknown Unknown s been signed by the should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an Hyperten sion has autops **Director:** After this certificate I 1 Yes 2 No 2 N Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No မြ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 🗌 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending ■ Natural injury work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check eractioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Signature an eted cause of death (Item 23a) (Type, Print) 9200 lds

State

Registrar

JAN 2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Winifred Drucilla Myers January 28, 2012 5:18 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 25476 Military Rd. Washington Cas cade 5. Social Security Number Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) If Under 8. Date of Birth **Funeral** Months Days Hours Mary Land 217-42-8823 Yrs. **Director** 68 1943 June Usual Residence of Decedent 28a-f show 10c. City, Town or Location 10a. State 10b. County notified at 10d. Inside City Limits Director 1 🗌 Yes 2 🛶 No Md. Washington Cascade 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? and Mental Hygiene. 'is marked other than "natural", or items 23a or raumatic event, the Medical Examiner must be I Funeral 25476 Military Rd. 21719 U.S.A within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11, Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No If Yes, Give X Year or Dates. þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Homemaker Elementary/Seconday (0-12) College (1-4 or 5+) Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Menta Important: If item 27 is marked any injury or other traumatic enone. ပ္ Charles W. Smith Bertha M. Lewis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gordon C. Myers (Husband) 25476 Military Rd. Cascade, Md. 21719 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Jan. Data 0. Bethel Cemetery

Competery

Competery

Competery

Competery

Competery 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cascade, Md. 2012 Signature of Funeral Service Licensee 22. Name and Address of Facility 12525 Bradbury Ave. M01414 J.L. Davis Funeral Home Smithsburg, Md 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine burial-transi Cause (Disease or linjury that initiated events and resulting in death) Last Due to (or as a co sequence of) attending physician for use as the buria Physician/Medical certificate be 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ Box in the past 12 month Hospital or Attending Physician: The law requires that the death signed by the atte Month Day Year Unknown 9 🗌 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed plnous 24a. Was an Were autopsy findings available prior to completion of cause of page 2 s autopsy performed death? 2 No 2 1 Yes Division of Vital director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 Tyes 2 No မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1. Natural 5 Pending work within 24 hours after death.

To the Funeral Director: A completed filled in by the fu 1 🗌 Yes 2 🗌 No 2 Accident Investigation Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 □ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the pause(s) and manner as stated. 29b. Signature and title of certifier coal 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHAHAB 2 87 2337 (QUIII 324 E 31. Date filed (Month, Day, Year) State FEB 0 9 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ^{Day} 2012 ROSE LEE NELSON FEB. 8:00A 3 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 6351 NELSON DRIVE LA PLATA CHARLES . Social Security Number 7. Age (In vrs. last birthday) 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 231-52-3838 Director 1 ☐ M 2 🛣 F 74 7-31-1937 Yrs VA. Usual Residence of Decedent 28a-f show must be notified at 10a State 10c. City. Town or Location 10d. Inside City Limits Director MD. CHARLES LA PLATA 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 9 10g. Citizen of What Country? 23a Funeral 6351 NELSON DRIVE 20646 U.S.A. death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. ō þ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give X Year or Dates. hours after Maryland 21215-0036 1 ☐ Yes 2 ☐ Yo Specify Specify: WHITE "natural" 3 Widowed 4 Divorced Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4 or 5+) the HOMEMAKER OWN HOME 7th other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F မ LARKIN GREER VIRGIE PICKLE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau once. FRANCIS A. NELSON-SPOUSE 6351 NELSON DRIVE LA PLATA, MD. 20646 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place 2-8-12 TRINITY Donation 5 Other (Specify) MEM.GARDENS WALDORF, MD. M00479 22. Name and Address of Facility RAYMOND FUNERAL SERVICE, P.A. PLATA, MARYLAND 20646 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause of a ch line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of Due to (or as a consequence of) resulting in death) Last Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death for use 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Day Pregnant at time of death No Unknown 9 Unknown be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ emu 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy 1 ☐ Yes 2 ☐ No 1 Tyes 25. Was case referred to medical To Be 26. Place of Death (Check only one) Other: 1 Yes No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) filled in by the funeral 28a. Date of injury (Month, Day, Year) Certificate: Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accider
3 Suicide Investigation 6 Could not be after death 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State within 24 hours a To the Hospital Medical 29a. Certifier ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State

29b. Signature an

29d. Date signed (Month. Dav. Year

	ey, II State 1-For State		ack indelible if Department of Certificate of	f Health and I		giene	20	12 0371	
Physician/ Medical Examiner	Registrar 1. Decedent's Name (First, Middle,La ADAM CLAYTON		II			2. Date of Death Month January 22		3. Time of Death 1847 hrs	
	4a. Facility Name (if not institution, g 14100 Bramble Court #2			4b. City, Town, or Loc Laurel	ation of Death		4c. County of Prince Ge	eorge's	
Funeral Director	578-19-7290	Sex 7. Age XM 2 F	e (In yrs. last birthday) 21 Yrs	Months Days	f Under 24Hrs. Hours Min.	8. Date of Birt		Birthplace (State or Foreign Country)	
land f show any puce.		Georges	10c. City, Town or Locat	on				10d. Inside City Limits 1 Yes 2 X No	
to the Maryland 3a or 28a-fshow office at once.	10e. Street and Number 14100 Bramble (Court #202		10f. Zip Code 20708	3	10	g. Citizen of Wha	t Country?	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiens after the file and the state of the file and the state of the file and the state of the s	11. Marital Status 1 X Never Married 2 Married 3 Widowed 4 Divorce	1 X Yes 2 If Yes, Give Year 2	No 2008 - 1	s Decedent of Hispan es, specify Cuban, Me Yes 2 X No sp	exican, Puerto F	Rican, etc.)	White, Specify:	Black	
5-0036 od within 72 hours tygiene. other than "natur like Medical Exam Completed I	15. Decedent's Education (Specify Elementary/Secondary (0-12) 12th	College (1-4 or 5	during m	t's Usual Occupation ost of working life. DO istrative	NOT use retire	nt	16b. Kind of Busi NASA	ness/Industry	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 7 permit. Pages I and 2 should be filed within 7 mportant: Mitem 37 is marked other than injury or other tranmatic event, the Medica To Be Comple	17. Father's Name (First, Middle, Las Adam Clayton Ows 19a. Informant's Name/Relationship	sley	19b Mailing		aldread	e Willi		State Zin Code	
and 2 shou cealth and N	Valdreace Willia 20a. Method of Disposition		787	Catherine	Fran Dr		okeek, N		
timore t. Pages 1 tment of H rtaut: If it y or other	1 Burial 2 Cremation 3 4 Donation 5 Other Specification	y:	Metropolit	an Cremato			Alexand	ria, VA.	
Physician /Medical	21. Signature of Funeral Service Lice 23a. Part I. Enter the disease, or comfailure. List only one cause on a	L. WINA	43	ame and Address of F Shall—Mar 08 <u>Suitlan</u> he mode of dying, such	d Rd.	Suitlar	nd, MD 20	Approximate Interval Between Onset and	
Examiner	Immediate Cause (Final disease or condition resulting in death)	Due to (or as a conse						Death	
ted Insit Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulti								
execu an and al - tra		AMENDED #5,T	per fh,g929	7-19-12 sı	n .				
certific certific nding p ise as th	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknow	23c. If yes, outcom 1 Live birth 4 Pregnant at t	2 Fel	al death 3 E	ctopic pregnan	су	23d. Date of de Month	elivery Day Year	
ires that the signed by the detach	Part II. Other significant conditions	contributing to death	but not resulting in the u	nderlying cause given	in Part I.		2 ✔ No 3	te to the cause of death? Probably 4 Unknown	
Division of Vital Records, P.O. Box for the Hospital or Attending Physician: The law requires that the death within 24 hours after death. The taw requires that the death or the Funeral Director: After this certificate has been signed by the attended property filled in by the funeral director, page 2 should be detached for underical Certification: To Be Completed by Physic	25. Was case referred to medical	_		26 Place of F	Death (Check or	24a. Was ar autops perform 1 Yes 2	y prid ned? dea	re autopsy findings available or to completion of cause of ath? Yes 2 No	
f Vital Physician Prysician er this cert ral directo		Hospital: 1 Inpatier	nt 2 ER/Outpatient				Residence 6	Other: Scene	
Division of Vital Recoputal or Attending Physician: The I outs after death. After this certificate I filled in by the funeral director, page Certification: To Be Com	27. Manner of Death 1 Natural 5 Pending 2 Accident Investiga		1819 hrs	1 Yes	2 ✓ No S	28d. Describe ho subject shot	ow injury occurred self		
Division or spital or Attending hours after death burs after death birector: After filled in by the fune Certification:	3 Suicide 6 Could no determine	t be	ury - At home, farm, stree ti-Family Apt.	t, factory, office buildi		or Town, Sta		or Rural Route Number, City turel, MD	
To the Hospital within 24 hours. To the Funeral completely filled	one) 2 Medical Examine		knowledge, death occurr ination and/or investigati	on, in my opinion, dea	ath occurred at	the time, date a	nd place, and due	to the cause(s)	
	29b. Signature and title of certifier 29c. License number 29d. Date sign 29d. Date sign 29d. Date sign 29d. Date sign 29d. Date sign								
R 10+1		Assistant Medical	Examiner 900 W	. Baltimore Stree	et, Baltimore	e, MD 21223	3		
State Registrar	31. Date filed (Month, Day Year) JAN 2 7 2012	32. Registrar	Signature						
DHMH 17 Rev 1/2001 OCME 2006	OGME (ORIGINAL						

Megan Taylor Pulleyn

		1- For State Registrar		Certificate d	of Death			Reg. No.				
Physicia cal Exami		Decedent's Name (First, Middle,La: Megan Taylor	Pulleyn			10	2. Date of Do Month	Day Y	'ear	3. Time of Death 0651 hrs		
		4a. Facility Name (if not institution, given		4b. City, Town	, or Location of D		danuary 28, 2012 0651 hrs 4c. County of Death					
		Route 544 West of Route	290		Crumpto	n		Queer	Anne's	3		
Funeral Director			o the state of the									
Director	Director 214-08-2295 1 M 2 F 26 Yrs. Months Days Hours Min. March 19 19 Usual Residence of Decedent									ountry) Delaware		
any		10a. State 10b. County	10c. (City, Town or Loca	ation					10d. Inside City Limits		
	ŗ	Maryland Queen A	nne				1 Yes 2 No					
Maryland 28a-f show d at ooce.	Director	10e. Street and Number		Milling	10f. Zip Cod	e		10g. Citizen of \	What Cou	ntry?		
WD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "outural", or items 23a or 28a-f sho matic evect, the Medical Examiner must be outfied at occ.		2313 Millington	Road		2165	1		U.S.A.				
tems 2	Funeral	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ever i Armed Forces?		as Decedent of Yes, specify Cu	Hispanic Drigin? ban, Mexican, Pu	(Specify Yes or Nerto Rican, etc.)		ce - Ameri nite, etc.	ican Indian, Black,		
ter dea			1 Yes 2 ∑ N If Yes, Give Year	0 1	Yes 2X	No specify:	•	Specify		White		
5-0036 led within 72 hours after Hygiene. other than "catural", the Medical Examine.	d b	15. Decedent's Education (Specify o	or Dates:		ent's Usual Occu	pation (Give kind	of work done	16b. Kind of I				
6 172 h	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)			life. DO NOT use	retired)					
within giene.	E	12 17. Father's Name (First, Middle, Last)	5+	Doct	or of P		457	hospi				
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c eveot, the Medica	Be C	Carlton W. Smit				Joan B	ame (First, Middle	, Maiden Surnan	ie)			
ould b d Men s mar		19a. Informant's Name/Relationship (T	-	19b, Mailir	ng Address (S		or Rural Route No	umber, City or To	wn, State	, Zip Code)		
ore, MD 21215-00 ss 1 and 2 should be filed win of Health and Mental Hygien If item 27 is marked other her traumatic evect, the M		Schuyler Pulley				_	d; Milli	ngton, l	MD 21	651		
imore, MD 2121 Pages I and 2 should be filment of Health and Mental Laot: If item 27 is marked or other fraumatic evect,		20a. Method of Disposition 1 Burial 2 X Cremation 3		b. Place of Dispo crematory or o	sition (Name of ther place) Cr	cemetery,	Date	20c. Location	ı - City or	Town, State		
Baltimore, Permit. Pages 1 a Department of He Important: If ite		4 Donation 5 Dther Specify.		hesapeal	ce Crema	tion Ja	an 30 20					
Baltimore, MI permit. Pages 1 and 2 s Department of Health a Importact: If item 27 injury or other traum:	- 1	21. Signature of Funeral Service Licen	see 1	22. E 1	Name and Addr	ess of Facility P	0 Box 16 nbein Fu	0; Green	nsbor	o, MD 21639		
hysician	\dashv	23a. Part I. Enter the disease, or comp	lications that caused the de							Approximate Interval		
Medical Examiner	-	failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or se a consequence of): Due to (or se a consequence of):										
	ğ		Due to (or as a consequenc	e of):								
	Examiner	Cause. Enter Underlying Cause (Diseas > or in jury that initiated cevents resulting in death) Last Due to (or as a consequence of):										
outed nd ransit												
760, cate be executed physician and the burial - trans	edical	UNPENDED	AMENDED									
	₹ŀ	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of pr					23d. Date of	,			
Box 68 death certificate death certificate death certificate death certificate death		past 12 months?	4 Pregnant at time of		etal death ther <i>(Specify)</i>	3Ectopic pre	gnancy	Month	D	ay Year		
. a . a	₽L	1 Yes 2 No 9 V Unknown	9 Unknown									
P. O. S. that s that	হ	Part II. Other significant conditions	contributing to death but no	t resulting in the	underlying caus	e given in Part I.				the cause of death? ably 4 Unknown		
ords, w require s been si	ate						– 24a. Was			opsy findings available		
e law i	Completed		·					ormed?	death?	ompletion of cause of		
	ပ္ဆို	25. Was case referred to medical			26.Pla	ce of Death (Che		2 No	2 No 1 Yes 2 No			
Vital yysician: this certifi I director,	To Be	examiner? 1 ✓ Yes 2 No	ospital: 1 Inpatient 2	ER/Outpatient		Other -		Residence 6	Other:	Scene		
	٦	27. Manner of Death 1 Natural 5 Deading	28a. Date of Injury (Month, Day Year) Jan 28, 2012	28b. Time of t 0637 hrs	njury 28c. Ir	jury at Work?		how injury occur struck by au				
Division tal or Atteodi rs after death.	ĕ ĕ	2 Accident 5 Pending Investigation	n			Yes 2 ✔ No						
Divi	Certification:	3 Suicide 6 Could not be determined		home, farm, stre	et, factory, office	building, etc.	or Town.			al Route Number, City		
Hospi 24 hou Fooer tely fil	ا <u>د</u>	4 Homicide 29a. Certifier 1 Certifying Physicia	in: To the best of my knowle	edge, death occur	red at the time.	date and place, a						
Division To the Hospital or Atteodi within 24 hours after death. To the Fooeral Director: completely filled in by the fi		one) 2 Medical Examiner:	On the basis of examination and manner stated.	and/or investigat	tion, in my opini	on, death occurre	d at the time, date	and place, and	due to the	cause(s)		
	Σ 2	29b. Signature and title of certifier	, /			nse number		29d. Date sign				
		YM.	1		0.0	S.M.E.		January 2	∍, 2012 ——			
	ľ	30. Name and address of person who co Jack Titus MD. Deputy (ompleted cause of death (Ite Chief Medical Examin	,	Baltimore St	reet. Baltimo	re, MD 21223					
Sta	te ³	31. Date filed (Month, Day, Year)	- 1			, = =				40		
Registr	ar	JAM SA ZUIZ	13 12 0	17								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ D45AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death IRSING HOME PARDL last birthday) If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🔽 Months Days Hours Min Director permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside Çity Limits Director 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral JSA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 1 Yes 2 No If Yes, Give Year or Dates Specify: WHITE Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8728 HOUSTON BRANCH RD FEDERALSBURG, MO 21632 THOMAS 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) aure of Funeral Service Licensee Hato SBLRG, MD 21632 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) crebrova Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to make cause. Enter Underlying Cause (Disease or iinjury Examine Duki to for as a consequence of signed by the attending physician and d be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ____ in the past 12 morths?
1 Yes 2 No Pregnant at time of death Month Day Year Unknown Unknown P.O. I Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed 2 🗆 No Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Tes 2 🖬 No Other: 0 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After 1 Natural 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type,

DHMH 17 Rev 7/2009

Registrar's Signature

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 3012 Rockwell Jovce Ann Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City. Town, or Location of Death Allegany WMHS-RMC Cumberland 9. Birthplace (State or Foreign Country) MD 6. Sex 7. Age (In yrs. last birthday) 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Hours Min Jun 23, 1944 Director 215-42-4798 1 🗆 M 2 🔀 F 67 Usual Residence of Decedent 10a. State at 10c. City, Town or Location Director 10d. Inside City Limits notified a 28a-f Cumberland MD Allegany 1 Yes 2 X No 10e. Street and Number 10f. Zip Code r items 23a or iner must be n ö 10g. Citizen of What Country? Funeral 21502 12613 Wilson Lane SE USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 14. Race - American Indian, Black, White, etc Examin ō þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify If Yes, Give Year or Dates "natural" Specify: Completed 3 Widowed 4 Divorced white Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) other than vent, the Me Elementary/Secondary (0-12) College (1-4 or 5+) of Health and Mental Hygiene. fitem 27 is marked other tha r other traumatic event, the I Registered Nurse Hospital 4 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Ruth Decker John Horchler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code Ernest Rockwell MD 21502 12613 Wilson Lane SE husband Cumberland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 0 1 X Burial 2 Cremation 3 Removal from State Department of Important: If any injury or Restlawn Memorial Gardens 1/26/2012 MD LaVale Donation 5 Other (Specify) 22. Name and Address of Facility Scarpelli Funeral Home, PA anatui of Funeral Servi 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between shock, or heart failure. List only one cause Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) oronau Medical Due to (or as a consentience of **Examiner** Sequentially list conditions, it are the cause. Enter Underlying Cause (Disease or injury Examine Due to for as a consequence of attending physician and I for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death Pregnant at time of death 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Day the Division of Vital Records, P.O. þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? this certificate 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: ျ 1 Inpatient 2 ER/Outpatient 3 IDCA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 Yes 2 No Certificate: 28d. Describe how injury occurred 24 hours after death. Funeral Director: After 14 Natural 5 Pending Accident Investigation filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one) 29b. Signature and title 0003328

Registrar

DHMH 17 Rev 06-2011

State

625 Kent Ave. Ste. 101 Cumberland, MD

of perso, who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 0540 AM Physician/ ASTEKAR 20/2 01 Medical 4a. Facility Name (if not institution, give street and number) Hospital 4b. City Town, or Location of Death 4c. County of Death **Examiner** ROCKVILLE MONTGOMERY GROVE ADVENTIST Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 8. Date of Birth **Funeral** 219-81-3987 (Month, Day, Year) Director 1 □ M 2 😿 F 08 1935 10 IRAN shov 10a. State 10c. City, Town or Location items 23a or 28a-f sho her must be notified at Director with the Maryland MONTGOMERY 1 Yes 2 No GERMANTOWN MD 10f. Zip Code 10e. Street and Numbe 10g. Citizen of What Country? Funeral 20874 IRAN 14161 GALLOP TERRACE 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 0 þ 1 Never Married 2 Married Yes 2 No Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify. Specify: WHITE "natural", Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene.

is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) OWN HOME HOME MAKER other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 RASTEKAR NOT AGHABALA KNOWN permit. Page 1 and 2 sh.
Department of Health an.
Important: If item 27 is m.
any injury or other. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GALLOP SON GERMANTOWN, MD. 20874 14161 HOSSEIN TARLAN Baltimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Date RKLAWN MEM EX 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 22/12 ROCKVILLE MD. 4 Donation 5 Other (Specify) 22. Name and Address of Facility ADEN MUSLIM FUNERAL SER. 21. Signature of Funeral Service Licensee MO #1070 42.EAS N HOODBRIDGE VA-22191 Y ST. 23a. Part 1. Enter the hease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediat Lause (Final 529519 Physician/ nours disease or condition Medical resulting in death) s a consequence of): **Examiner** heumonia dous Sequentially list conditions, if any, leading to immediate Examine sician and burial-transit Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last igned by the attending physician be detached for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☒ No 4 Pregnant at time of death Month Year Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by fibrillation 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No arthritis 24a, Was an autopsy performed? Yes 2 No this certificate funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be after death 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 000 6948 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ROCKVILLE MD DRIVE D. NGUYEN MD 9931 CENTER MEDICAL 31. Date filed (Month, Day, Year, 32. Registrar's Sign State JAN 2 5 2012 Registrar

DHMH 17 Rev 06-2011

0240

R

0

			Pleas	e Type or Pri								_	ible.		
		1 - State of Maryland / Department of Health and Certificate of Death								2012 03716					
		Registrar 1. Decedent's Name	Certii	icate of L	Jeani	2. Date of De	Reg. No. 2. Date of Death			3. Time of Death					
Physicia Medio		Catherine	e Elizab	eth Smith				Januar	y 2	2°, 20	1 ^{Year}	11:20 P M			
Examin		4a. Facility Name (if not institution, give street and number) 4b. City, Tov							Location of Dea	ith	4c. County of Death				
Function		Citizens Care Center 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)						Frede f Under 1 Year	erick If Under 24 Hr	s. 8. Date of Bi	Frederick			.C.K. place (State or Foreign	
Funeral Director		219-20-3030 Usual Residence of Decedent						lonths Days			, 1926 Maryland				
/land f show d at	ţo	10a. State	10c. City, Town or Location								1	0d. Inside City Limits			
e Mary r 28a- notifie	Funeral Director	Maryland 10e. Street and Num	rick	Frederick									1 ☒ Yes 2 ☐ No		
vith the	rail	1900 Rose									What Coun State	-			
eath v	Fune	11. Marital Status	12. Was Decedent	Ever in U.S							Т	14. Race - American Indian,			
s after d ral", or it Examine	ą	1 ☐ Never Marri 3 🛣 Widowed	Armed Forces? 1 Yes 2 X If Yes, Give Year or Dates.	No	If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify:							Black, White, etc. Specify: White			
2 hour	plet	(Spe	15. Decedent's	Education grade completed)				t's Usual Occupa d of work done d		orkina	16b. Kind of Business Industry			dustry	
ithin 7 ene. • than	Completed	Elementary/Seco		College (1-4 or	5+)	Ì		IOT use retired)		J		Ow	n Hon	ne	
iled w I Hygi other vent, t	Be	17. Father's Name (F	First, Middle, Las	t)					18. Mother's N	ame (First, Middle	, Maide	n Surname	e)		
id be f Menta arked atic ev	입	Ira Victo	or Miss,	Sr.					Lillia	n Burdet	te				
d 2 shoulalth and 1 27 is mer trauma		19a. Informant's Name/Relationship (Type, Print) Janet L. Darcey / Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or To 18710 N. Ridge Drive, Hagerstown,									or Town, S	r Town, State, Zip Code) ., MD 21740			
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.				Removal from State	20b. P	Rest	Disposition of the Company of the Co	on (Name of or or other place Sardens	e) Jan	. 27, 2012			City or To	wn, State Maryland	
permit. P Departm Importa any inju		21. Signature of Euneral Service Licensee Restria aveni Fufficial Services, Skkot Cody P.A. 9501 Catoctin Mountain Hwy. Frederick, MD 21										P.A.			
		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between													
Physician/ Medical	Examiner	Immediate Cause (F) al disease or condition resulting is death seed to the condition of the													
Examiner		Due to (or as a consequence of):													
sit sd		Sequentially list con if any, leading to im cause. Enter Under Cause (Disease or i	nmediate rlying	b. Due to (or as	a consequ	consequence of):									
e executed ian and urial-transit															
ate be physic the bu	dice			d									-		
Physician: The law requires that the death certificate be ethis certificate has been signed by the attending physicianal director, page 2 should be detached for use as the burnal	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1									23d. Date of Month			ery Day Year	
at the d by the letache										tobacco	acco use contribute to the cause of death?				
requires that the de been signed by the should be detached	ted by							,						pably 4 Unknown	
sician: The law rescrificate has be irector, page 2 sho	Completed									perf	opsy ormed?	I	orior to con death?	osy findings available mpletion of cause of	
ian: Ti rtificat stor, pa	Be C	25. Was case referre examiner?	ed to medical					26. Pla	ace of Death (Ch		2 🔀	No	1 🗌 Yes	2 L No	
hysic his ce al direc	오	1 🗆 Yes 2 🛭		Hospital:				3 DOA Othe	er: 4 🛛 Nursing	Home 5 🗆 Res	idence	6 🗆 Othe	er (Specify)		
ending Physician: "aath. nr: After this certifica ne funeral director, p	Certificate:	27. Manner of Death 1 X Natural 2 ☐ Accident	5 Pending Investigat			28b. Tin inju	ury	28c. Injury work' M 1 🗆		28d. Describe	how inju	ury occurre	ed		
al or Atte s after de I Directo d in by th		3 ∐ Suicide 4 □ Homicide	6 ☐ Could no determine	28e. Place of Inji	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)				
To the Hospital or Attending P within 24 hours after death. To the Funeral Director. After the completed filled in by the funeral	Medical	(Check 2	Medical Exa	hysician: To the best of miner: On the basis of e urse Practioner: To the	xamination	and/or i	investiga	tion, in my opinio	n, death occurre	d at the time, date	and place	ce, and due	e to the cau	ise(s) and manner stated.	
To the comp	2	29b. Signature and		Photo D		KIOWIC)	29c, License	number	/			d (Month, L		
^		1		o completed cause of d	leath (Item			t)	3971	. ,		101	112		
3		Robert L					9th	Street	, Frede	rick, MD	217	.01	_		
Stat Registra		31. Date filed (Monti	JAN 25	2012 32. Registra	ar's Signat		pa	ekel							

Division of Vital Records, P.O. Box 68760 & Baltimore, Maryland 21215-0036

		Pies For State	State of M		d / Depa	artmer	t of H	ealth a		lental Hy	giene	20	ible.	00717
Physiciar	1/	Registrar 1. Decedent's Name (First, Middle		-	Cer	tificat	e or D	realii		2. Date of Dea	Reg. No. ath Day		Year 12	3. Time of Death
Medica Examine		Helen Mae Sh 4a. Facility Name (if not institution 3020 N. Ridg	, give street and number)					Location o		2	4c.	County Owar	of Death	12:30a M
Funeral Director		5. Social Security Number 202-07-5632		ge (In yrs. las	t birthday) Yrs.	If Under Months		If Under		8. Date of Birl (Month, Da 7 / 7 / 19	:h			lace (State or Foreign ry)
aryland ka-f show ified at	ector	Usual Residence of Decedent 10a. State 10b. County MD How	vard		Town or Loc					<u> </u>			. 10	Od. Inside City Limits
s 23a or 28	Funeral Director	10e. Street and Number 3020 N. Ridg	e Rd., W220			10f. Zip	Code 1043				10g. Cit	izen of W	Vhat Count	ry?
rs after death iral", or item Examiner m	þ	11. Marital Status 1 ☐ Never Married 2 ☐ Mar 3 ☑ Widowed 4 ☐ Divorced	If You Give		1:	Vas Deced f Yes, spec	ify Cubar	n, Mexican	gin? (Spe , Puerto	ecify Yes or No- Rican, etc.)			e - America k, White, e whi	tc.
ithin 72 hour ene. than "natu he Medical	Completed		nt's Education est grade completed) College (1-4 or	5+)	life. D		rk done di retired)	ation uring most	of worki	ng			isiness/Ind	
d be filed w Mental Hygi arked other atic event, t	To Be	17. Father's Name (First, Middle, L Lester L. Bo	,		366	· · · · · · · · · · · · · · · · · · ·				e (First, Middle, M. Sweż	Maiden S	Surname		
and 2 shoul Health and I em 27 is mi ther traums		19a. Informant's Name/Relationsl Elizabeth He 20a. Method of Disposition			152 C	otta	ge Gr	ove 1	Dr.,	Pasade	na,	MD 2	1122	
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		1 Burial 2XXCremation 4 Donation 5 Other (S	Specify)	ce/	nation nation	Soc	ther place Lety	06	2/6	r Crema	Kin	g 06		ssia, Pa s of Pa., I
be ey siciar burit	dical Examiner	23a. Part . Enter the disease, or shock, or heart failure. List of immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as c. Due to (or as Due to (or as	a conseque	ence of):	11 -	,	81 S		or respiratory an	rest,			Approximate Interval Between Onset and Death
To the Hospital or Attending Physician: The law requires that the death certificate I within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome 1	2 Fetal	death 3	Ectopic Other (sp		/				23d. Dat Mor	e of delive	ry Day Year
quires that the	<u>ک</u>	Part II. Other significant condition	ons contributing to death		_		h	en in Part I	l.					e cause of death?
The law rec cate has bed page 2 sho	Completed		0	•						24a. Was autor perfo 1 Yes	rmed?	p	Vere autop rior to con leath?	sy findings available npletion of cause of 2 No
/sician s certifi director	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	tient 2 🗆 E	B/Outpatien	ıt 3 🗆 D(Othe	r:		ne 5 Resid	tence 6	Othe	r (Specify)	
ending Phy sath. or: After thi he funeral	Certificate: 1	27. Manner of Death 1 🔀 Natural 5 🗆 Pendir 2 🗀 Accident Investig	28a. Date of injung (Month, Date of gation	ury 2	8b. Time of injury	-	8c. Injury work?	at		28d. Describe h				
oital or Atturus after de eral Directo		3 Suicide 6 Could 4 Homicide determ	lined 28e. Place of Inj building, et	c. (Specify)						28f. Location (S City or Tow	n, State)			·
o the Hosp vithin 24 ho o the Fune ompletely	Medical	(Check 2 Medical E	Physician: To the best of examiner: On the basis of Nurse Practitioner: To the	examination a	and/or invest	igation, in death occ	my opinior	n, death oc ne time, dat	curred at	the time, date a	nd place, he cause	, and due (s) and m	to the caus	se(s) and manner stated. tated.
F > F 0		> Am	- 1-0			Ī	200	35	30	9	2	12	12	
ϕ		30. Name and address of person Sandra Sattin,	who completed cause of 6 MD 2850 N.	death (Item 2 Ridge	Road	rint) • #10	3, E	llico	itt (City, Mi	21	043		
State Registra		31. Date filed (Month, Day, Year) FFR 0 9 2012	32. Registr	rar's Signatur	re arkal									

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 201^{rea} 8:15 a. M Robert Earlston Smith 18. January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Frederick Walkersville Glade Valley Nursing Home 5. Social Security Number 6 Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Funeral Days Hours 219-44-4626 67 Director 1 1 M 2 | F July 27, 1944 Maryland Usual Residence of Decedent show or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Frederick Walkersville Maryland Maryland 1 K Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 21793 USA 8309 Water Street Road 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. 1XX Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes X No Specify: **Black** If Yes, Give 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene, other than " 5+^{College (1-4 or 5+)} Elementary/Secondary (0-12) Teacher Education other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental ! ပ John Henry Smith, Jr. Helen Louise Butler other traumatic 19a. Informant's Name/Relationship (Type, Print)

John H. Smith, II -19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Left the second of the second brother 5616 Gary Avenue, Alexandria, Virginia 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 1-23-2012 Stauffer Crematory Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Livensee 22. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, Maryland 23a. Part 1. Enter the disease, or complications that caused he death. Do not enter the mode of dying, such as cardiac or respiratory arrest interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Metadastic Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it may be some to immediate cause. Enter Underlying Physician/Medical Examiner Due to lor as a consequence of that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a I for use as the burial-Box 68760 IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day Month Year Pregnant at time of death 9 Unknown 9 Unknown P.O. signed by to be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 K No 25. Was case referred to medical examiner? Division of Vital Be 26. Place of Death (Check only one) Hospital: ဂ္ 1 ☐ Yes 2 🗶 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c, Injury at 28d. Describe how injury occurred Hospital or Attending 1**₩** Natural 5 Pending injury work? 1 Yes 2 No Accident Investigation 24 hours after dearn Funeral Director: Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying, Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year, 1343091 1-19-2012

Registrar
DHMH 17 Rev 06-2011

8

State

Tou

House

801

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Zaidi

31. Date filed (Month, Day, Year)

MA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** Dorothy Elizabeth SCHLOSSER 40 am)9 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Hagerstown 9. Big/hplace (State or Foreign Karenwood Nursing enter 8. Date of Birth (Month, Day, Year)
July 24,1921 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🕽 F Hours Min Mary Land 90 Yrs Director 219-14-7576 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ?7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the "Modical Experiment must be notified at Washington Hagerstown 1 □Yes 2 No Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21742 U.S.A. 19800 Tranquility Circle Suit 203 and Mental Hygiene. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 No Specify: Completed by Specify. 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) her own home homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Louise Lowman Robert Charles Triesler ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health a
Important: If item 27 is
any Injury or other trau Carolyn J. Ardinger - daughter | 7010 Pack House Drive, Hope Mills, NC 28348 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State January 31, Hagerstown, Maryland Rose Hill Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service License Minnich Funeral Home 415 East Wilson Blvd., Hagerstown, Maryland 21740 23a. Party Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, should, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Bartrompsener Week /Medical Due(to (or as a consequence of): Examiner week mann Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine for as a consectuence To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes ☑ No 24a. Was an certificate has birector, page 2 s autopsy performed? Yes 210 No 1 🗆 Yes within 24 hours after death.

To the Funeral Director: After this certifit completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 □ Natural 2 □ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description:

Description: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated.

DHMH 17 Rev 1/2001

State Registrar

29b. Signature and title of certifier

31. Date filed (Month Pay

en

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SH

Registrar's Signatur

368

Stud Hersexentro 2/140

		1	For State Registrar		State of	f Marylar		artmen tificate			and M	lental Hy	gien Reg. N	20	12	0372
F	Physician	/	1. Decedent's Name Robert (2. Date of De Month 01-20	eath		Year	3. Time of Death 6:15 A M
	Medica Examine	_	4a. Facility Name (if		give street and numb	ber)			Town, or	Location	of Death		4	c. County o		
	Funeral Director	L	5. Social Security No. 201-34-4 Usual Residence of	4580	6. Sex 1 🕅 M 2 🗍 F	7. Age (In yrs. I	ast birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir 9-12-1			9. Birthp Count	lace (State or Foreign ry) PA
aryland	a-f show ified at	- 1-	10a. State	10b. County Talb	ot	10c. Cit	y, Town or Loc				-				10	0d. Inside City Limits 1 X Yes 2 □ No
with the M	23a or 28		10e. Street and Nun		ate Drive	1		10f. Zip	Code 216	501			10g. (Citizen of WI	hat Count	ry?
nd 21215-0036 filed within 72 hours after death with the Maryland	p in	6	11. Marital Status 1 Never Marri 3 Widowed	ied 2 🛚 Marri	12. Was Deced	ces? 2 No		Vas Deced Yes, spec	ent of His ify Cubar	spanic Ori n, Mexicar		cify Yes or No- Rican, etc.)		14. Race	, White, e	tc.
Maryland 21215-0036 2 should be filed within 72 hours after	r than "natur the Medical	Completed	(Spe Elementary/Second 12				16a. Deced (Give I life. Do	aind of wor NOT use	k done di	ution uning mos	t of workir	ng		Kind of Bus		ustry Ompany
land 2	rked othe	ωŀ	17. Father's Name (Albert (1802					(First, Middle,	Maide	n S <i>ur</i> na <i>m</i> e)	00 0	ompany
, Maryl	ealth and in 27 is ma	Ī	19a. Informant's Na					g Address O Mea				Route Numbe		or Town, Sta		
Baltimore, permit. Page 1 and	Department of he Important: If iten any injury or other once.	2	20a. Method of Disp 1 ☐ Burial 2 4 ☐ Donation	Cremation	3 ☐ Removal from S	State Ch	Place of Dispo- emetery, crent sapeak Cen	sition (Name of the Cre	e of her place mati	on	_	-2012		Location - C		
Balti permit.	Importa any inju		21. Signature of Fur	. 1 -		RLER	Fe Fe	Name and	Address He	of Facility of Eacility of Eacility	bein		nam	Funer	al H	ome, P.A.
N N	i i _a n Medical		23a. Part 1. Enter the shock, or hear Immediate Cause (disease or condition resulting in death)	t failure. List or Final	a. Due to (o	h line.	h. Do not ente	r the mode	of dying	, such as		respiratory ar				Approximate Interval Between Onset and Death
Exa	aminer		Sequentially list coi if any, leading to im cause. Enter Under	nditions, nmediate	b	r as a consequ										
50 te be executed	ysician and he burial-transit	EXall	Cause (Disease or i that initiated events resulting in death) L	iinjury	c. Due to (d	r as a consequ	uence of):									
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate b within 24 hours after death.	been signed by the attending physician and should be detached for use as the burial-transit and by Dhysician Modical Examples of the Dhysician Modical Examples	ysiciali/imed	F FEMALE: 23b. Was decedent in the past 12 r 1 Yes 2 2 9 Unknown	nonths?		irth 2 🔲 Feta ant at time of c	ıl death 3 🗔	Ectopic p		′			Ċ	23d. Date Mont		ry Day Year
Is, P.O.	n signed by	IL for no	Part II. Other signifi	icant condition	s contributing to de	ath but not res	ulting in the u	nderlying o	ause give	en in Part i	l.					e cause of death?
Record The law req	cate has been signed, page 2 should be de	and lines										24a. Was autor perfo	psy ormed?	pri de		sy findings available apletion of cause of
of Vital	his certifi Il director		25. Was case referre examiner? 1 Yes 2 2	Î No	28a. Date o	npatient 2 finjury	ER/Outpatien 28b. Time of injury		Othor	4 L Nu at	ırsing Hor	only one) ne 5 KResid 8d. Describe h				
ivision or Attendir after death.	Director: After thin by the funera		2 Accident 3 Suicide 4 Homicide	5 Pending Investiga 6 Could not determine	ot be 28e. Place of	of Injury - At ho g, etc. (Specify	me, farm, stre	M et, factory,	1 🗆 Y	∕es 2 🔲		28f. Location (S City or Tou			or Rural F	Route Number,
B Hospital	he Funeral I		(Check 2	Medical Ex	Physician: To the be aminer: On the basis Nurse Practioner: To	of examination	and/or investi	gation, in n	ny opinior	n, death oc	curred at	the time, date a	and plac	e, and due to	o the caus	se(s) and manner stated
To the within	To th		29b. Signature and t		dyanatha	~ M		29c.	License				29d. D	ate signed (Month, D	
10+	VA		LAKSHMI	VAID	ho completed cause YANATH F	1N, 21°	1 S. W.		NG.	TON	ST,	EAST	ron) N	ND.	21601
₹ —	State Registrar		1. Date filed (Month	AN 23	2012 32.6	gistrar's Signat	B. A	auth)								
DHMH 17	7 Rev 7/2009	9														

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Thelma Louise Sho
4a. Facility Name (if not institution, give street and number, Medical Shorter 2012 7 • 55 **Examiner** 4b. City, Town, or Location of Death 4c. County of Death <u>Genesis HealthCare</u> The Pines Talbot <u>Easton</u> Age (In yrs. last birthday)
7 2 Yrs. If Under 1 Year If Under 24 H **Funeral** 8. Date of Birth 9. Dirthplace (State or Foreign 217-36-1431 Days Months Hours Min Director 1 1 - 1 8 - 1939 Maryland Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits Md. Kent 1 Yes 2 No Worton 10e. Street and Number ò 10f. Zip Code "natural", or items 23a o 10g. Citizen of What Country? Funeral 26520 Big Woods Road 21678 USA filed within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. Armed Forces?
1 ☐ Yes 2 🛣 No 1 Never Married 2 Married ģ Shorter Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: Completed 3 Widowed 4 Divorced Specify: Black the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Il Hygiene. Church Elementary/Seconday (0-12) College (1-4 or 5+) 12 United Methodist of Health and Mental Hygie If item 27 is marked other or other traumatic event, the House keeper/Cook Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic Wilson Thelma Bernice Bennard Smith 19a. Informant's Name/Relationship (Type, Print) Husband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Dudley Shorter/ 26520 Big Woods Rd. Worton, Md. 21678 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 ☐ Other (Specify) Church Cem. 01-21-12 NCCOL Worton, Md. 22. Name and Address of Facility Bennie Smith Funeral Home Funeral Service Licenses 855 High St., Chestertown, Md. 21620 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on even line. Approximate Interval Between Immediate Cause (Final Onset and Thath Physician/ disease or condition Medical resulting in death) Examiner near Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Pregnant at time of death Dav Year the 9 Unknown 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performet? Yes 2 No certificate 2 🗌 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2-No 2 Hospital 1 Yes Other : After this c funeral dir 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 \square Pending in 24 hours after con.....he Funeral Director: Aft — vatural ☐ Accident ☐ Suic! injury 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, ☐ Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check within 2. Certifying Nurse Practioner: the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier

2/4 DHV

DHMH 17 Rev 7/2009

State Registrar m 23a) (Type, Print)

610

Name and address of person who completed cause of death

ROWLEY

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 0^{Month} 16 Day 2012 Robert L. Sutton, Sr. 13:05 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Washington Adventist Hospital Takoma Park Montgomery Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Birthplace (State or Foreign Country) (Month, Day, Year) 243-80-5849 1 XM 2 □ F 61 **Director** NC March 6, 1950 or 28a-f show notified at 10a. State 10b. County the Maryland 10c. City, Town or Location Director 10d. Inside City Limits 1 🏋 Yes 2 □ No DC Washington 10e. Street and Number 10f. Zip Code 9 10g. Citizen of What Country? ms 23a or must be permit. Page 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Examiner must b. Funeral 5002 Hunt Place, N.E. 20019 IIS 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates 3 Widowed 4 X Divorced Specify: **Black** Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12th College (1-4 or 5+) Materials Handler Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Johnnie Sutton, Sr. Ruth Murray 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tina L. Sutton/Daughter 3256 N.W. 93rd Street, Miami, FL, 33147 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Resurrection Cemetery 1-28-2012 Clinton, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Pope Funeral Homes, P.A. ire of Funeral Service Lig 5538 Marlboro Pike, Forestville, MD20747 Part 1. Anter the disease, or complice shock, or heart failure. List only one or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, st only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) **Examiner** Jemmor Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Exami Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury for use as the burial-tran that initiated events resulting in death) Last and Due to (or as a consequence of attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy 5 Other (specify) Month Day Year Pregnant at time of death signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown been sig Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has director, page 2 performed 24 hours after death. Funeral Director: After this certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ္ 1 Yes 2 UNO 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner eath Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 5 Pending 1 - Natural injury 2 Accident
3 Suicide
4 Homicide Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 3 only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 29c. License number 01-16-12 0 00

State Registrar TAH

14

MD

Silm Des

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (*Month, Day, Year*)

JAN 2 7 2012

BILD

32. Registrar Signat

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 20/ 182/ M Physician/ ohnson Medical Prince County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Hospital nce George's Chevert If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex (Month Funeral Days Min Months Hours 1 🗆 M 2 💢 F 1181 Virginia 229-78-3299 3 **Director** Usual Residence of Decedent 10d. Inside City Limits th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County be filed within 72 hours after death with the Maryland Director 1 Yes 2 No Prince anham 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral USA 20706 281 Oa ane Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever in U.S. Armed Forces? 11, Marital Status Black, White, etc. 2 No þ 1 Never Married 2 Married 1 Yes
If Yes, Give Specify: Black 1 ☐ Yes 2 X No Specify: Baltimore, Maryland 21215-0036 3 Widowed 4 Divorced Completed Year or Dates 16b. Kind of Business Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) <u>ministrative</u> Billing Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ Johnson aarfield 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Health tem 27 cott-Vaughter Croom /ammie 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition permit. Page 1 Department of Important: If it Burial 2 Cremation 3 Removal from State Hauge Virginia 28/2012 4 Donation 5 Other (Specify) Jerusalem Church Cem. injury Faith Funeral Service 22. Name and Address of Facility French 21. Signature of Funeral Service Lice is ea any Dunkick, MD 20754 101576 Southern Maryland Blvd 10684 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Arterosclerotic Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of): that initiated events Due to (or as a consequence of) resulting in death) Last the attending physician hed for use as the buna by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant Live Birth 2 Fetal death 3 Ectopic pregnancy Month Day in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) 9 Unknown Division of Vital Records, P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. completed filled in by the funeral director, page 2 should be det 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 2 🗆 No 2 - No 1 🗌 Yes Yes 26. Place of Death (Check only one) 25. Was case referred to medical examinera

Yes 2 No Other: Hospital: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 IDOA Certificate: To 28d. Describe how injury occurred 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 27. Manner of Death injury 1 Natural 5 Pending 1 Yes 2 No Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) Accident 24 hours after deat Funeral Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie mpleted cause of death (Item 23a) (Type, Print)

Registrar

State

3001

Tald

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 Blanche Victoria Usilton January 3:15 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Caroline Nursing Home Denton Caroline 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 2/6/1917 Maryland 1 □ M 2 X F Months Days Hours Yrs Director 220-16-7622 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important if item 27 is marked other than "natural" any injury or other traumatic events. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Caroline Greensboro Maryland 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 511 N. Main Street 21639 USA 11. Marital Status Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married ☐ Yes 2 X No Yes, Give 1 ☐ Yes 2 X No Specify. 3 ₩ Widowed 4 Divorced Completed White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Familv Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Henry Clay Woolford Anna Greaves 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Victoria Baynard/daughter Pinehurst Circle Easton, Maryland 21601 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 💹 Burial 2 🗆 Cremation 3 🗆 Removal from State Church Hill Cemetery 1/25/2012 Church Hill, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licen 22. Name and Address of Facility Moore Funeral Home, P.A. local South 2nd Street Denton, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Corovar Medical Due to (or as a consequence Examiner Each antiply list on alltices Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): use as the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 ves, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

The string of death 5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No ó Month Day Year be detached Unknown signed by 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s certificate has autopsy performed?

Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 No Other: 1 🗌 Yes ဂ္ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural work? 1 ☐ Yes 2 ☐ No 5 Pending ☐ Accident ☐ Suicide ☐ Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Registrar

State

29b. Signature and title of certifier

201

32. Registrar's Signature

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 26

	R	- For State legistrar_		Certif	icate of	Death		,	Re	eg. No.	UI	2 03/
Physiciar Medical Examin	er	1. Decedent's Name (First, Middle, La Shirley Ann	Vito						d. Date of Dea Month January 2	Day Yea 8, 2012		3. Time of Death 0410 hrs
		4a. Facility Name (if not institution, g Anne Arundel Medical Ce	·		41	c. City, Town, Annapolis		of Death		4c. County Anne Aı		
Funeral Director		223-44-2192	Sex 7. Age ((In yrs. last t	birthday) Yrs.	If Under 1 Y Months D			8. Date of Bir	th (MM/DD/YYY) /1936	Foreig	hplace (State or n Virginia untry)
Maryland 28a-f show any d at once.	o N	Jsual Residence of Decedent 10a. State 10b. County Anne Ar 10e. Street and Number			wn or Location Water	n 10f. Zip Code			10	Og. Citizen of WI	hat Coun	10d. Inside City Limits 1 Yes 2 No
with the Maryland ns 23a or 28a-f sho be notified at once		1607 Fullerton R	oad			21037				USA		
Rer death	by Fune	11. Marital Status 1 Never Married 2 X Marrie 3 Widowed 4 Divorce 15. Decedent's Education (Specify	1 Yes 2 A	No No	If Yes	s, specify Cub res 2 X t s Usual Occup	no specify:	kind of wor	rk done		e, etc. Whit	
5-0036 ed within 72 hc tygiene. other than "na	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)		during mo: Homema	ker				Own H		
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than c event, the Medica		7. Father's Name (First, Middle, Las William T. Ho	ttle				18.Mother			Maiden Surname Lfflett)	
MD 21 d 2 should 1 lth and Mer n 27 is man umatic ev	2 1	9a. Informant's Name/Relationship (Joseph P. Vito/			1607	Fuller	ton Ro		al Route Num	ber, City or Tow Cer, MD	2103	37
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours all Department of Health and Mental Pyggene. Important: If item 27 is marked other than "natural injury or other traumatic event, the Medical Examin	1	0a. Method of Disposition Burial 2 X Cremation 3 Donation 5 Other Specify Signature by Fryneral Service Lice	y:	crem	atory or other as Cre	matory		1-31	Date -2012	Edgewa Talas Fu	ter,	Maryland
Depril De		Il Mall			297	3 Solo	mons I	sland	l Rd. E	Edgewate	r, M	ID 21037
Physician /Medical =:xaminer	1	3a. Part I. Enter the disease, or com failure. List only one cause on e mmediate Cause (Final disease a or condition resulting in death)		Approximate Interval Between Onset and Death								
	s	Sequentially list conditions, b	Due to (or as a consequ				··					
red nisit		fany, leading to immediate ause. Enter Underlying Cause Disease or injury that initiated c										
cuted md transit		vents resulting in death) Last	Due to (or as a consequ	ŕ								
ficate be executed g physician and the burial - transit	200	X UNPENDED	x _{AMENDED} 23a, ₁ 29d, per me	et.II,	27, per 2-22-	me,g9 12 sm	924 2-	22–12	sm	<u> </u>		
certif	23	FEMALE: b. Was decedent pregnant in the past 12 months? Yes 2 X No 9 Unknow	23c. If yes, outcome 1 Live birth 4 Pregnant at tim 9 Unknown		2 Fetal	death 3 r (Specify)	Ectopic	pregnanc	y 	23d. Date of Month	delivery Da	ay Year
P.O. BOX s that the death med by the atter detached for the box by Physician	P	art II. Other significant conditions	contributing to death be	ut not resulti	ing in the und	derlying cause	given in Par	rt I.				ne cause of death?
ds, P.C equires that een signed I	מופת ר	Hypercholester		st Can	cer,Cl	ronic	<u>Obstru</u>	<u>ict</u> iv	24a. Was a			bly 4 Unknown
		Pulmonary Disea	se				(David		autops perform 1 ✓ Yes 2	ned? d	nor to co eath? Yes	mpletion of cause of
f Vital Physician or this cert ral directo	5	5. Was case referred to medical examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpatient	2 🗸 ER/	Outpatient		Other4	Nursing H		Residence 6	Other:	
After funera		7. Manner of Death Natural 5 Pending	28a. Date of Injury (Month Day Year) Jan 28, 2012	28b	o. Time of Inju 20 hrs		ury at Work?	- 1	d. Describe h	ow injury occurre	ed	
Division o spital or Attending to use after death. meral Director: After filled in by the function:	3	Suicide 6 Could not	be 28e. Place of Injury	/ - At home,	farm, street,	factory, office	building, etc		or Town, Sta			al Route Number, City
Division To the Hospital or Attention within 24 hours after death within 12 hours after death completely filled in by the Hospital Centrification	29	Da. Certifier 1 Certifying Physic Check only 2 Medical Examine	ian: To the best of my kr r:On the basis of examin and manner stated	nowledge, dation and/or	eath occurre	d at the time, n, in my opinio	date and place on, death occ	ce, and du	e to the cause e time, date a	(s) and manner nd place, and du	as stated ue to the	f. cause(s)
	29	b Signature and title of certifier	Jest	1 mi	80		.M.E.			^{29d.} Date signe		h, Day,Year)
D	30	Name and address of person who Assistant Medical Exa				imore. MD	21223			-14114		
State Registra	e ³¹	Date filed (Month, Day, Year)	32. Registrar's									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Month IONE M. VanMETRE 10:22 P M JAN **2**012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death HAGERSTOWN AUTUMN ASSISTED LIVING WASHINGTON Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 99 Days Hours 1 M 2 X F 1/7/191 234-36-6133 WEST VIRGINIA **Director** Usual Residence of Decedent 28a-f show 10b. County or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director SHEPHERDSTOWN **JEFFERSON** 1 X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 25443 208 WEST HIGH STREET USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 XNo Black, White, etc 1 \square Never Married 2 \square Married Maryland 21215-0036 WHITE If Yes, Give Year or Dates 1 ☐ Yes 2 ☐XNo Specify: Specify: Completed 3 ☑ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working Elementary/Seconday (0-12) life. DO NOT use retired) College (1-4 or 5+) **HOMEMAKER** OWN HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
BESSIE HARDESTY age 1 and 2 should be filed ent of Health and Mental H nt: If item 27 is marked of y or other traumatic even ည DANIEL HOLLAND MOLER 19a. Informant's Name/Relationship (Type, Print 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. CHARLES W. VanMETRE/SON PO BOX 101, SHEPHERDSTOWN, WV 25443 Baltimore. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State W☐ Burial 2 ☐ Cremation 3 ☐ Removal from State JANUARY 27, ☐ Donation 5 ☐ Other (Specify) ROSEDALE CEMETERY MARTINSBURG WV 21. Signature of Funeral Service Licensee 22. Name and Address of Facility BROWN FUNERAL HOME, PO BOX 821, 327 W. KING ST., MARTINSBURG, WV 25402 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ARTERIS SCLERE TIC CARDIOVASCULAR disease or condition YRC Medical resulting in death) DUSEASE Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or iinjury Due to (or as a consequence of): that initiated events Due to (or as a consequence of): resulting in death) Last ng physician a Physician/Medical Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by MYPERTENSION ALZ WEIMERIS of Vital Records, 1 Yes 2 No 3 Probably 4 Onknown been 3242 2) G 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed? Yes 2 No within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 1 🗌 Yes 2 🗀 No or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Living 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural injury 5 Pending Division 1 ☐ Yes 2 ☐ No Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number -out ma 21,2012 D0018 019 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 340 m.115T MD AGERSTOWN 32. Registrar's Sympton State

DHMH 17 Rev 7/2009

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Gary Lee Valentine Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Western MD Regional Medical Center Cumberland Allegany Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** 219-46-0191 **Director** 1 X M 2 🗆 F 65 01/04/1947 Maryland Usual Residence of Deced with the Maryland 10a State 10c. City, Town or Location 10d. Inside City Limits Director 28a-f MD Allegany Cumberland 1 X Yes 2 No 10e. Street and Number o 10f. Zip Code ıs 23a oı ∗r must b 10g. Citizen of What Country? Funeral 21 Blackiston Avenue 21502 USA items? permit. Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No 1966— If Yes, Give Year or Dates. 1968 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or iten edical Examiner r 11. Marital Status Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify. Completed 3 - Widowed 4 X Divorced Specify White 1968 Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) r than " the M Elementary/Secondary (0-12) College (1-4 or 5+) f Health and Mental Hygien item 27 is marked other the other traumatic event, the Caregiver Non-profit Org. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Raymond Robert Valentine, Sr. Anna Bealky 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Coc Jason C. Valentine / Son 10 N. Southwood Avenue, Annapolis, MD t: If item 2' 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date ᇹ 1 💢 Burial 2 🗆 Cremation 3 🗆 Removal from State Department of Important: If any injury or once, MD Vet Cem @ Rocky Gap 01/23/2012 Flintstone, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Alams Family Funeral Rome, F.A. re of Funeral Service Lice 404 Decatur Street, Cumberland, MD 21502 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line dr complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final et and eath Ph_sician/ neumon disease or condition Medical resulting in death) **Examiner** Cequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of). attending physician and for use as the burial-transit resulting in death) Last Due to (or as a consequence of) Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Dav Pregnant at time of death Year 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performe hours after death. 1 Yes 2 No 1 ☐ Yes 2 😿 No To the Hospital or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospita Other: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death . Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work?
1 Yes 2 No 28d. Describe how injury occurred Natural 5 Pending iniury Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 28f. Location (Street and Number or Rural Route Number, within 24 hours a

To the Funeral C

completely filled Medical 29a. Certifier 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year, KOHIT JAZH MD D-70131 20 2012 01 4+ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KON 12500 Willowsbecok Road Gemberland 32. Registrar's Signature State Registrar

NK UNK		- For State	ite of Marylar		artment of rtificate of		and	Menta	al Hyg		g. No. 20	12	0372
Physician	1	Registrar 1. Decedent's Name (First, Middle	Last)						2	. Date of Deat Month	g. 140.		. Time of Death
مطical Examine المحمد		Vivian Marie W: 4a. Facility Name (if not institution		ber)		4b. City, Tow	vn. or Le	ocation of I		January 2	5, 2012 4c. County of	Death	1135 hrs
1	ı	Big Elk Creek near EB				Elkton	,				Cecil		
Funeral	T	5. Social Security Number	6. Sex 7	'. Age (In yrs. I	ast birthday)	If Under 1	Year Days	If Under 2	24Hrs. Min.	8. Date of Birt	h(MM/DD/YYYY)	9. Birthp oreign	place (State or
Director		220 00 3730	1 M 2 X F	5	O Yrs		Days	Hodrs	141111.	2/26/	1961	Coun	try) MD
any	-	Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Locat	ion						1	0d. Inside City Limits
E .	_	MD Ce	ei1		E1kton							1	X Yes 2 No
the Maryland a or 28a-f show tified at once.		10e. Street and Number				10f. Zip Co	ode			10	g. Citizen of What	Country	p
or items 23a or 23a-f sho must be notified at once		504 ½ Hollings			- Lie iii	219			0.4.0		US		- Indian Dian
ath wi	= I	11. Marital Status 1 ☐ Never Married 2 ☒☒Mai	12. Was Dece	ces?		es, specify (cify Yes or No- ican, etc.)	White,		n Indian, Black,
	<u>8</u> -	3 Widowed 4 Divo	1 Yes rced If Yes, Give Yeer or Dates:	2 X No	1	Yes 2X	No	specify:			Specify:	Whi	te
hours a		15. Decedent's Education (Speci	fy only highest grade		16a. Deceden during m	it's Usual Oc ost of workin					16b. Kind of Busin	ness/Ind	ustry
136 thin 72 lee. than "; edical I	ompiered	Elementary/Secondary (0-12)	College (1-4	4 or 5+)	Commo	mod o 1	C1 -				0.16.7		
21215-0036 July be filed within 7 Mental Hygiene. marked other than c event, the Medica	ᇹ	12 17. Father's Name (First, Middle, I	.ast)		Comme	<u>rcial</u>	18	B.Mother's	Name (F	irst, Middle, M	Self E Naiden Surname)	<u>Impl</u>	oved
be file be file irked (ent, ti		Benjamin Abbott	;		4			Nola	C1a	rk			
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once To Ro Commissed by Elineral Directors	2	19a. Informant's Name/Relationsh Michael S. Wild		and							ber, City or Town,		
and 2 sho lealth and trem 27 is traumati		20a. Method of Disposition		20b.	Place of Dispos	ition (Name	ngs of ceme	etery,	n AV	e · LIK	ton, MD 2 20c. Location - C	ity or To	L wn, State
Baltimore, permit. Pages l an Department of Her Important: If ite	- 1	1 X Burial 2 Cremation	_	II Glate	crematory or oth 11y Hil		neta	rsz 2	121	2012	Baltimo	re	MD
Baltin permit. P Departme Importar injury or	ŀ	4 Donation 5 Other Spe 21. Signature of Funeral Service	ciry: icensee	1110.		lame end Ad					d Funeral		
		1			25	9 East	Ma	in St	ree	t, Elki	ton, MD 2	2192.	1
, Physician /Medical	1	23.f. Part I. Enter the disease, or of failure. List only one cause of	n each line.				lying, si	uch as card	diac or r	espiratory arre	est, snock, or neart		Approximate Interval Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a c			rmia						\dashv	
		Sequentially list conditions,	b Due to (or as a c		n.							\dashv	
		if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	Due to (or as a c	onsequence o	11 7.								
ted Insit	EX	events resulting in death) Last	Due to (or as a c	consequence o	rf):								
0, e be executed rsician and burial - transit	<u>-</u>	X UNPENDED	AMENDED 2	3a,27,2	28a-f,pe	er me,	g934	4 12-	4-12	2 sm		\Box	
760, cate be physici the buri		IF FEMALE:		utcome of preg	nancy						23d. Date of de		
Box 6876C death certificate the attending physed for use as the b		3b. Was decedent pregnant in the past 12 months?	I L Live bill	th nt at time of de		tal death her <i>(Specify</i>	3 _	_Ectopic p	regnand	ey .	Month	Day	Year
. Box 6876 the death certificate by the attending phy ched for use as the Dhyseinian/M	E L	1 Yes 2 No 9 Unkr	a Ouknow										
	7	Part II. Other significant condition	ns contributing to o	death but not r	esulting in the u	underlying ca	iuse giv	en in Part	I.		bacco use contribu		cause of death? Iy 4 Unknown
w requires is been signatured believed.	Completed								_	24a. Was a			sy findings available
Division of Vital Records, tel or Attending Physician: The law require ra after death. al Director: After this certificate has been siled in by the funeral director, page 2 should be artification: To Be Completed	Ē									autops perform	med? dea	or to com ath? Yes	npletion of cause of
tal Rec		25. Was case referred to medical				26.		f Death (C	heck on				
Vital Physician: r this certif	<u>∘</u> L	examiner? 1 ✓ Yes 2 No		patient 2	ER/Outpatient						Residence 6		cene
ion of tending Pheath. or: After the funeral		27. Manner of Death 1 Natural 5 Pendi		Day,Year)	28b. Time of I			atWork? s 2 X N	s s	ubject	ow injury occurred found in	cr	eek and
Atten Atten er death rector: by the	<u>E</u>	2 Accident Invest	igation 28e Place	25–12 of Injury - At h	fd 10:2 ome, farm, stree	25 am			e:	xposed	to cold	env:	Route Number City
Div	Certification	4 Hamisida deterr	nined (Specify)	Cree	k				رم	or Town, St mbankme	ate)Big Filk ent Rt 40	Cre	ek near or to RE213
Division To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the			vsician: To the best	of my knowled	ge, death occur	red at the tir	ne, date	and place	e, and du	ue to the cause	ALD • e(s) and manner es	stated.	auso(s)
To th within To th comp	ᇟᆫ	one) 2 Medical Exam 29b. Signature and title of certifier	and manner sta		ind/or investigat			number	ineu at t	ne time, date a	29d. Date signed		
		or and the property of					D.C.M				January 26, 2		,,,
6	-	30. Name and address of person	vho completed cause	of death (Item	n 23a)								
۲		Donna M. Vincenti, MD				W. Baltin	nore S	Street, B	Baltimo	ore, MD 212	223		
Stat Registra		31. Date filed (Month, Day, Year) FEB U 9 2012	32. Reg	istrar's Signati	barks!								

OCME

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 3. Time of Beath 4:55A 2. Date of Death Physician/ JANUARY DOROTHY 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) Min. Days Hours 218-82-9577 **Director** 1 M 2 🔽 F 83 Dec. 22, 1928 Virginia Usual Residence of Decedent 28a-f show 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.
item 27 is marked other than "natural", or items 23a or 28a-f shor other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits Director 1 X Yes 2 □ No Maryland Frederick Mount Airy 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 606 Prospect Road 21771 United States 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc 1 Never Married 2 Married þ ☐ Yes 2 🔯 No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White 3 XX Widowed 4 ☐ Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) . Page 1 and 2 should be filed tment of Health and Mental Hy tant: If item 27 is marked otl 18. Mother's Name (First, Middle, Maiden Surname) မ Fleming Oscar Worell Nettie Florence McPeak 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Melvin O. Webb, Sr. / Son 606 Prospect Rd., Mt. Airy, MD 21771 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Jan. 24. Reschaven 0 1 🗵 Burial 2 🗆 Cremation 3 🗆 Removal from State permit. Page Department of Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) 2012 Frederick, Maryland Memorial Gardens 21. Signature of Freal Service Licensee Resthaven Funeral Services, Skkot Cody P.A. 9501 Catoctin Mountain Hwy. Frederick, MD 21701 23a, Part I. Enter the disease or omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. It is only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ meum on/a disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Exami The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Pregnant at time of death ed by the a detached i Unknown P.0. signed by d Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 1 XYes 2 No 3 Probably 4 Unknown Completed . Were autopsy findings available prior to completion of cause of 24a. Was an cate has by page 2 s autopsy perforn death? certificate Yes 2 No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 🗷 No 4 Nursing Home 5 Residence 6 Other (Specify, 1

✓ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of within 24 hours after death.

To the Funeral Director: After tompletely filled in by the funer 28c. Injury at 28d. Describe how injury accurred 1 X Natural 5 \square Pending iniury work? 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 Certifying Physiciam To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On he basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year, D4309 1-20-12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3 Tou House Ane, Frederick, MO 801 Jacer Zaidi MN 31. Date filed (Month, Registrar's Signature State J. B. C. Arth Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month Katherine Elizabeth Wolfe Linuary Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Lions Center for Rehab & Ext Care Allegany Cumberland 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Davs Hours 08/25/1914 214-05-7161 Director 1 □ M 2 🛛 F Maryland Usual Residence of Decedent show 10a. State 10c. City, Town or Location notified at Director 28a-f MD Allegany Cumberland 10e, Street and Number 10f. Zip Code ō 10g. Citizen of What Country? Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be I Completed by Funeral 901 Seton Drive 21502 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? 1 Yes 2 No Black White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 hatherine wolf If Yes, Give Year or Dates 1 ☐ Yes 2 🌠 No Specify: 3 X Widowed 4 Divorced White Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Beverage Co. Co-Owner and Operator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frank Catlett ၉ Rosetta Martin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 330 Kitchen Orchard Road, Hedgesville, WV Diane Broadwater / Niece 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Page 1 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Hillcrest Mem. Park 01/20/2012 Cumberland, MD 22. Name and Address of Facility Adams Family Funeral Home, Sunature of Funeral Service License 404 Decatur Street, Cumberland, MD 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 for use as the IF FEMALE: yes, outcome of pregnancy ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? 1 Yes 2 No 9 Unknown 5 Other (specify) Month Pregnant at time of death Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes After this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law 1 24 hours after death. Funeral Director: After this certificate has b autopsy Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 No Other: ဂ 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) completely filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury Natural 5 Pending work? 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 within 2 To the 1 only one)

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

3. Time of Death

10d. Inside City Limits

1 X Yes 2 No

25427

Approximate Interval Between

Onset and Death

Dav

29d. Date signed (Month. Day, Year,

Rd Cumberland MP 21502

Smertly

Year

2:05AM

Registrar DHMH 17 Rev 06-2011

State

10

2

29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

JAN 1

9

MOD

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 2012 165 Wagner Eileen Odelia Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Allegany WMHS-RMC Cumberland 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs Date of Birth 9. Birthplace (State or Foreign **Funeral** Country)PA Aug 14, 1948 **Director** 164-40-4276 1 □ M 2 □XF 63 28a-f show ortant: If item 27 is mart ed other than "natural", or items 23a or 28a-f sho injury or other traumatt. event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director LaVale MD Allegany 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 21502 USA 1235 Braddock Road W 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 X Married by Saltimore, Maryland 21215-0036 1 Yes 2 No Specify If Yes, Give Year or Dates Specify 3 Widowed 4 Divorced white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Registered Nurse Health Care 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Anna Folger William Allison 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1235 Braddock Road W LaVale MD 21502 John Wagner Sr. husband Important: If item 27 any injury or other tra 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State scarpelli Funeral Home, P.A. 1 🗆 Burial 2 🗆 🗴 remation 🛮 3 🗀 Removal from State 1/13/2012 MD Cresaptown Domation 5 Other (Specify) of Funeral Service 22. Name and Address of Eacility Scarpelli Funeral Home, PA 21. Signature 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1. Inter the diserte, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Physician/ IVETIDAUG disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Box (3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month 4 Pregnant at time of death g Unknown 1 ☐ Yes ∠ ∠ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à OBSINDETIVE Records, 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an has autops 1 Yes 2 No __ Yes 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) 1 Yes 2 □ No ပ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Date of injury (Month Day, Year) 28b. Time of o the Hospital or Attending Pl vithin 24 hours after death. o the Funeral Director: After th completely filled in by the funera 28c. Injury at Certificate: 28d. Describe how injury occurred 1 🔲 Natural 5 Pending 1110/12 1 Yes Investigation Accident OUGRAOS & 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined BRADAOCH Medical ECertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practifioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only on Signatu 29d. Date signed (Month, Day, Year) and address of person who completed cause of death (Item 23a) (Type, Print) JAN 19 32. Registrar's Signature

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 20 | 2 | State of Maryland / Department of Health and Mental Hygiene

		1- For State Criticate of Death Registrar	Reg. No.												
Physicia al Exami	an/	1. Decedent's Name (First, Middle,Last) Herman Lee Weaver Jr.	2. Date of Death Month Day	3. Time of Death Year 1746 hrs											
;ai Exaiiii	ner	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death	January 27, 2012 4c. Cou	inty of Death											
		Meritus Medical Center Hagerstown		hington											
Funeral Director		5. Social Security Number 217-42-8875 6. Sex 1 Months Days Hours Min.	8. Date of Birth (MM/DD/Y 8 – 12 – 194	YYY) 9. Birthplace (State or Poreign MD Country)											
and show any nce.	٥٢	Usual Residence of Decedent 10a. State MD Washington Clear Spring		10d. Inside City Limits 1 Yes 2 X No											
the Maryl: sa or 28a-f	Director	106. Street and Number 13504 Mercersburg Road 21722	10g. Citizen o U • S	f What Country? • A •											
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene, and If item 21 is marked other than "natural", or items 23a or 28a-f abow or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1 Never Married 2 Married Armed Forces? 1 Yes 2 No 3 Widowed 4 Divorced of Hispanic Origin? (Specify Cuban, Mexican, Puerto 15. Decedent's Education (Specify only highest grade completed) 16. Decedent's Usual Occupation (Give kind of w	Rican, etc.) V Spectork done 16b. Kind of	of Business/Industry											
036 ithin 72 hou ne. r than "nat	Completed	Elementary/Secondary (0-12) 12th grade College (1-4 or 5+) 2 equipment operator	ed) Cem	ent plant											
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be	Herman L Weaver Sr. Esther	(First, Middle, Maiden Surn Tona Keif	er											
MD 27 nd 2 should aith and Me m 27 is ma	19a. Informant's Name/Relationship (Type, Print) Darlene Weaver wife 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State Prematory or other place) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Spr. 13504 Mercersburg Rd. Clear Spr. 20c. Location - City or Town, Spr. 20c. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State Prematory or other place) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Spr. 20c. Location - City or Town, Spr. 20c. L														
Baltimore, MD permit. Pages 1 and 2 sho Department of Health and Important: If item 27 is injury or other traumat		4 Donation 5 Other Specify:	2012	ar Spring,MD											
Balt permit. Departs Importi		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Donald Edwin Th													
hysician /Medical															
Examiner		or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions,													
	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated													
xecuted n and l - transit		events resulting in death) Last d. UNPENDED AMENDED													
60, ate be e	Medical	IF FEMALE: 23c. If yes, outcome of pregnancy	23d. Da	te of delivery											
OX 687 ath certific attending r	Physician/I	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnant at time of death 5 Other (Specify) 9 Unknown	ncy Mon	th Day Year											
s, P.O. Be irres that the de signed by the d be detached f	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		contribute to the cause of death? 3 Probably 4 Unknown											
Division of Vital Records, P.O. ital or Attending Physician: The law requires that th ars after death. The Intercor: After this certificate has been signed by the funeral director, page 2 should be detach they the funeral director, page 2 should be detach	Completed		24a. Was an autopsy performed?	4b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No											
	Be C	25. Was case referred to medical examiner? Hospital: Inserting 25. Place of Death (Check 25. Place of Death (Check 26. Place of Death	,aq												
of Vit Physic Per this eral dire	To	1 ✓ Yes 2 No location 1 Inpatient 2 ✓ ER/Outpatient 3 DOA Norsin 27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work?	g Home 5 Residence 28d. Describe how injury or												
Division of pital or Attending Ph ours after death. eeral Director: After t filled in by the funeral	Certification:	1 Natural 5 Pending Investigation Pending 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc.	Subject driver of bob 28f. Location (Street and N	cat that flipped umber or Rural Route Number, City											
E 8 5 E		Suicide Could not be determined (Specify) Industrial Area 29a. Certifier 4 Continue Physician To the best of my knowledge death accounted at the time date and place and	or Town, State) Holcim Inc. 1260 Securi	ity Road, Hagerstown, MD											
To the Hos within 24 h To the Fun completely	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred a and manner stated.	t the time, date and place, a	and due to the cause(s)											
7	Σ	29b. Signature and title of certifier 20c. License number O.C.M.E.		signed (Month, Day, Year) y 28, 2012											
11-10		30. Name and address of person who completed cause of death (Item 23a) Victor Weedn MD JD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore	re, MD 21223												
V	tate	31. Date filed (Month Page Agar) 32. Registrar's Signature													

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1 - Department Name (First Middle act)												
			Decedent's Name (First, Middle, La.	st)				2. Date of Dea	th	3. Time of Death		
	Physicia Medio		Sarah Willis					Month 01-20	-2012	11:55 A M		
-	Examin		4a. Facility Name (if not institution, give			4b. City, Town, or	Location of Dea	th	4c. County of			
1			William Hill Man 5. Social Security Number 6. S		a dia una la at hinth da d	Easton If Under 1 Year	If Under 24 Hr	S 0 D-t (Dist)	Talbot			
	Funeral Director			M 2 🗓 F 7. Ag	e (In yrs. last birthday) 93 Yrs.	Months Days	Hours Mir			I. Birthplace (State or Foreign Country) MD		
- 2	å.		Usual Residence of Decedent					1, 11,				
	yland -f sho ed at	ctor	10a. State 10b. County		10c. City, Town or Loc	cation				10d. Inside City Limits		
	r 28a notifi	Director	MD Talbo	τ	Easton	10f. Zip Code			10g. Citizen of Wha	1 X Yes 2 No		
	with the 23a c	erai	501 Dutchmans La	ne		21601			USA	at Country?		
	leath items	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?		Vas Decedent of His Yes, specify Cubar	spanic Origin? (S	Specify Yes or No-		American Indian,		
36	within 72 hours after death with the Maryland glene. er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at	l by	1 Never Married 2 Married	1 ☐ Yes 2 X	No	☐ Yes 2X No		to rican, etc.)		White, etc.		
8	atura cal Ex	Completed	3 X Widowed 4 ☐ Divorced 15. Decedent's B	Year or Dates.	16a Decec	lent's Usual Occupa	ation		16b, Kind of Busin	White		
215	n 72 h an "n Medi	ldu	(Specify only highest gr Elementary/Seconday (0-12)		(Give I	kind of work done d O NOT use retired)	uring most of w	orking	100, KING OF EGSII	less industry		
2	I withi ygiene her th t, the		12	4		maker			Own Hom	ne		
Maryland 21215-0036	d be filed within 7 Aental Hygiene. Irked other than tic event, the M	To Be	17. Father's Name (First, Middle, Last) Alfred Grace					ame (First, Middle, I	Maiden Surname)			
Ž	ould bad Me mark	ľ	19a. Informant's Name/Relationship (7	vne. Print)	10h Mailir	g Address (Street a		Moore	City or Town State	a. Zin Codo)		
Z	d 2 sh alth ar 27 is er trau		W. Thomas Founta			Washingt			-	s, 21p code)		
ore,	ge 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. if item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at		20a. Method of Disposition 1 Burial 2 XX Cremation 3	Bomousi from Stato	20b. Place of Dispo	atory or other place	e)	Date	20c. Location - Ci	ty or Town, State		
Baltimore,	tmer tant tant jury		4 Donation 5 Other (Speci	fy)	Chesapea	ke Cremat enter	ion 1-2	2-2012		ville, MD		
Bal	permit Depar Impor any in once.		21. Signature of Funeral Service Licen	MERLE	$\mathcal{L}_{\mathcal{L}}}}}}}}}}$	Name and Addres ellows, I 00 S. Har	s of Facility Helfenbe rison S	in & New	nam Funer n MD 2160	al Home, P.A.		
			23a. Part 1. Enter the disease, or com shock, or heart failure. List only of	g, such as cardia	c or respiratory arre	est,	Approximate Interval Between					
	mysician/ Medical		Immediate Cause (Final disease or condition resulting in death)	a. TDYS	144614					Onset and Death		
1	Examiner			Due to (or as:	a consequence of):	DEMEN	ATTL			YEARS		
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury	b. Due to (or as:	1 consequence on:	200101	0 111.3			1 COTP S		
	cuted ind transit	Examiner	that initiated events	c								
	Hospital or Attending Physician: The law requires that the death certificate be executed for hours after death. Funeral Director: After this certificate has been signed by the attending physician and ated filled in by the funeral director, page 2 should be detached for use as the burial-transit	dical E	resulting in death) Last	Due to (or as a	a consequence of):							
3760	ficate g phys	Medio		l d				· · · · · · · · · · · · · · · · · · ·				
k 687	aath certifica attending pl I for use as tl	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnancy 2 Fetal death 3	Ectopic pregnance	V		23d. Date of	of delivery		
Вох	death the ath	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4 Pregnant a		Other (specify)	,		Month	Day Year		
P.O.	that the desired by the sidetached is		Part II. Other significant conditions of	ontributing to death b	ut not resulting in the u	nderlying çause give	en in Part I.	23e. Did to	bacco use contribu	te to the cause of death?		
S, F	v requires the been signer should be	Completed by	ATHERO SCHELL	oth Cher	010 VASCUL	Me Dis	LASE	1 □ Y	′es 2 □ No 3	☐ Probably 4 🌂 Unknown		
oro	aw requias been 2 shoul	plet						24a. Was a	n 24b. Wer	re autopsy findings available r to completion of cause of		
of Vital Records,	The law ate has page 2	Com						autop perfor	med? dea			
tal	ysician: The is certificate director, pag	Be	25. Was case referred to medical examiner?	Hospital:			ce of Death (Ch	eck only one)	19,0444			
Ž	Physic this cral din	2	1 Yes 2 No	1 Inpati	ent 2 ER/Outpatien	t 3 DOA Othe	4 Nursing	Home 5 Reside	ence 6 Other (S	Specify)		
o uc	ttending Ph death. ctor: After th the funeral	cate	1 Natural 5 ☐ Pending 2 ☐ Accident Investigation	(Month, Day		work'	yes 2 ☐ No	26d. Describe III	Jw Injury occurred			
Division	r Atter	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined		rry - At home, farm, stre	et, factory, office		28f. Location (Si City or Town		r Rural Route Number,		
Ö	oital o											
	To the Hospital or Attendii within 24 hours after death. To the Funeral Director: At completed filled in by the fu	Medical	(Check 2 Medical Exam	iner: On the basis of e	my knowledge, death o xamination and/or invest best of my knowledge, o	igation, in my opinio	n, death occurred	d at the time, date ar	nd place, and due to	the cause(s) and manner stated.		
	To the within 2 To the comple		29b. Signature and title of certifier		11/2	29c. License	number	2	29d. Date signed (N	fonth, Day, Year)		
	}		-/nta/anh	ATTEMO	ING INID	100	0726	7	1-22-7	2017		
	5			completed cause of d	eath (Item 23a) (Type, P	DOI	DALE 1	tue FE	152MLS	BURG MD		
	Stat Registra		31. Date filed (Month, Day, Year) JAN 23	2012 ^{32. Registra}	ar's Signature	facts						

DHMH 17 Rev 7/2009

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 0653AM January Dona1d Thurston Wiggins 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Easton Memorial Hospital at Talbot LASTON If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Director 214-66-9824 1 🛛 M 2 🗆 F 56 Jan 22 1956 Maryland Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Director 1 Yes 2X No Ridgely Maryland Caroline 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 21660 U.S.A. 11523 Holly Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ⚠ Yes 2 ☐ No If Yes, Give Year or Dates. 1974-80 11, Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 Widowed 4 X Divorced Specify: Completed Black 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 h and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4 or 5+) McDonald's Corporation Equipment Mechanic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Betty Hoxter George T. Wiggins Donald other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is any injury or other traumonce. 11523 Holly Road; Ridgely, Maryland Betty Murray/ mother 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Buriat 2 Cremation 3 Removal from State cemetery, crematory or other place) Eastern Shore Vet Cm Jan 27 2012 4 ☐ Donation 5 ☐ Other (Specify) Hurlock, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of FacilityPO Box 160; Greensboro, Fleegle and Helfenbein Funeral Home, PA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Ph_sician/ CARDOPULMONARY disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions Examine it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last physician a sthe burial-Physician/Medical SPRE Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 1 Yes 2 9 Unknown the been signed by the should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has to page 2 s performed 24 hours after death. Funeral Director: After this certificate 2 1 No Yes 2 No Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဂ္ Yes 2 No 1 ☐ Inpatient 2 M ER/Outpatient 3 ☐ DOA funeral 27. Manu er of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner) To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year, NO 1053055 1/23/2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ARCE! ELLAS 31. Date filed (Month, Day, Year) 22. Registrar's Signature State sous !

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month $20\overset{\text{Year}}{12}$ 5:10 P M 01 Williams Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Prince George's Forestville Health & Rehab Center Forestville If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days Hours Min. 1 M 2XX 09%01*/1*1938 Virginia Director 226-52-5887 73 Usual Residence of Decedent 28a-f show 10b. County 10d. Inside City Limits 10c. City, Town or Location at 10a. State Director Examiner must be notified MD Prince George's Capitol Heights 1 Yes 2 □ No 9 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 1207 Addison Road apt.#453 20743 USA death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. "natural", or 1 Never Married 2 Married \$ within 72 hours after Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 ☐XNo If Yes, Give Year or Dates Specify. 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 th and Mental Hygiene.
7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) 12th School Aide DC Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Wiley Thompson Bessie Wilkins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ge 1 and 2 sh nt of Health au : If item 27 is Greig Street apt. #203 Seat Pleasant, MD 20743 LaTonia Williams/Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) St. James CME Cemetery01/31/2012 Lawrenceville, VA 4 Donation 5 Other (Specify) 22. Name and Address of Facility Marshall-March Funeral Home 21. Signature of Funeral Service Licer 4308 Suitland Road Suitland, MD 20746 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition Ovarian Carcinema Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exam Cause (Disease or injury that initiated events requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of) resulting in death) Last physician s the burial Medical Box 68760 attending p IF FEMALE: f yes, outcome of pregnancy
Live Birth 2 Fetal death Physician/ 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No 9 Unknown Division of Vital Records, P.O. by signed k Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown cate has been signated by page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? this certificate 1 Yes 2 X No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical completed filled in by the funeral director, I 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 2 X No ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 X Natural work' 5 Pending 1 🗌 Yes 2 🗌 No □ Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 🛆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year, D0026024 01/25/2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Lester Miles 1160 Varnum Street NE Washington, DC 20017

Registrar

State

31. Date 134 Month, Pay 2012

race

32. Registrar's Signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ FEBRUARY DOROTHY LOUISE **ALLGOOD** 2012 6:20 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death FORT WASHINGTON NURSING HOME PRINCE GEORGE'S FORT WASHINGTON Social Security Number f Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, SEPT 1 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 1 □ M 2 X WASHINGTON, DC Director Yrs. 579-30-7812 192586 Usual Residence of Decedent 28a-f shov with the Maryland at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director notified 1 X Yes 2 ☐ No PRINCE GEORGE'S FORT WASHINGTON 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? must be Funeral 23a 12021 LIVINGSTON ROAD 20744 USA death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian Black, White, etc. ö þ 1 Never Married 2 Married 1 Yes 2 XNo Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after 1 Yes 2 X No Specify: BLACK Completed 3 ♥ Widowed 4 □ Divorced Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) ntal Hygiene. ed other than ' event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) TEACHER GOVERNMENT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) nd Mental F marked of 2 ELIZABETH SIMMONS LOUIS DUTCH other traumatic and is 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 CRYSTAL KELSON/DGT. 3 OTTO WAY FREDERICKSBURG, VIRGINIA 20a. Method of Disposition 20b. Place of Disposition (Name of Department of H Important: If ite any injury or of 20c. Location - City or Town, State Date 1 😾 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 🗋 Donation 5 🗆 Other (Specify) cemetery, crematory or other place, 2/9/2012 HARMONY CEMETERY LANDOVER, MARYLAND 21. Signature of Funeral Service Licenses 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME, INC. V36 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1/ Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart value. List only one cause on each line. Immediate Cause (Final Onset and Death Ph sician/ ATHEROSCLEROTIC CARDIOVASCULAR DISEASE disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Due to for as a consequence of: if any, leading to immediate cause. Enter Underlying Exami Cause (Disease or iinjury that initiated events and the burial-trar Due to (or as a consequence of): resulting in death) Last physician Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 SS attending IF FEMALE: nse yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Pregnant at time of death 5 Other (specify) Year 2 No the 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown page 2 should 24b. Were autopsy findings available 24a Was an certificate has prior to completion of cause of death? performed 1 Yes 2 XNo 1 ☐ Yes 2X No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 1 Yes 2 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Hospital or Attending (Month, Day, Year) 1X Natural 5 Pending death. 1 Yes 2 No neral Director: A Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined To the Funeral C Medical 29a. Certifie 🖾 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier. 29d. Date signed (Month, Day, Year) 1536-5 FEBRUARY 6, 2012

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month,

LIVINGSTON ROAD #101 FT. WASHINGTON, MARYLAND 20744

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MICHAEL SIDAROUS M.D. 11701

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

aylor All		1- For State Registrar	te or Maryland /	•	ificate of		nu ivien	tai nygieri	₽ Reg.	No. 20	112	0373
Physici Medical Exam		Decedent's Name (First, Middle, Taylor Alt	Last)						of Death n D uary 6, 2			me of Death
viedicai Exami	Hei	4a. Facility Name (if not institution,	give street and number)		4	b. City, Town, o	or Location of		uary 6, 1	2012 4c. County of		745 nrs
		Saint Agnes Hospital				Baltimore						
Funeral Director			7. Age	(In yrs. last	t birthday) Yrs.	Months Da 7	ys Hours	Min.	of Birth(1 /08/2		Foreign	Maryland
/ any		10a. State 10b. County		10c. City, To	own or Location	on			-		10d.	Inside City Limits
yland I-f show	tor	Maryland Baltim	ore	Cato	onsvill	e Mano	c					Yes 2 X No
e Mary or 28a fied at	Director	10e. Street and Number 1118 Wilson Ave	ກນອ			10f. Zip Code 21 20	7			Citizen of Wha		
n, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland ealth and Mental Hygiene. tem 27 is marked other than "antural", or items 23a or 28a-f she fraumatic event, the Medical Examiner must be notified at once	_	11. Marital Status 1 X Never Married 2 Marr	12. Was Decedent	Ever in U.S.		Decedent of H	ispanic Orig	gin? (Specify Yes , Puerto Rican, e	s or No-	Inited S	American In	
ter dea			1 Yes 2 Ced If Yes, Give Year	X No	1	Yes 2 🔀 N	o specify:		,		White	<u>.</u>
ours af	ed by	15. Decedent's Education (Specification)	or Dates:	pleted) 16	6a. Decedent		ation (Give I	kind of work done	16	b. Kind of Busi		
5-0036 led within 72 hours afte Hygiene. other than "natural", the Medical Examiner	Completed	Elementary/Secondary (0-12)	College (1-4 or 5		-		e. DO NOT	use retired)		NT / 7		
21215-0036 wild be filed within 7 Mental Hygiene. marked other than	Con	17. Father's Name (First, Middle, La	ast)		Never	Worked	18.Mother	's Name (First, M	iddle, Maid	N/A den Surname)		
2121 2121 Mental H marked ic event, t	Be	Daryl Marvin Al						nne Jam				0 kC (C4
MD 2 td 2 should the and Multh and M	욘	19a. Informant's Name/Relationship Roxanne Boissea						e Catons				
Te, N 1 and 2 Health Fitem 2		20a. Method of Disposition		20b. Pla		ion (Name of c		Date		Oc. Location - C		
Pages Pages nent of or othe		1 Burial 2 Cremation 4 Donation 5 Other Spec	arv:		ntic C	remator	y	02/13/20	012 G	len Bur	mie,	Maryland
Baltimore, MD 212 permit Pages I and 2 should be Department of Health and Ment Important: If item 27 is mark injury or other traumatic ever		21. Signature of Funeral Service Li	6unsee		22. Na Dav	ime and Addres	s of Facility Veber	Funeral	Home	s P.A.		
Physician	1	23a. Part I. Enter the disease, or co		he death. Do	531	1 Edmor	ndson	Avenue 1	Balti	more, M	App	nd 21229 proximate Interval
Medical Examiner		failure. List only one cause or Immediate Cause (Final disease	a. Sudden Un	explai	ined De	ath In	Infan	ncy(SUDI)		Bet	tween Onset and Death
		or condition resulting in death)	Due to (or as a consec	quence of);								
	miner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a consec	quence of):								
I iit	Exam	(Disease or injury that initiated events resulting in death) Last	Due to (or as a consec	quence of):	-			<u> </u>				
tox 68760, eath certificate be executed a strending physician and for use as the burial - transi	Sal	X UNPENDED	d AMENDED 23a,	27 28	a-f ne	r mo mo	027 5	-2-12 am				
60, ate be e thysicia	Medical	IF FEMALE:	23c. If yes, outcom			ı me,mg	921)-	-2-12 SII		23d. Date of de	elivery	
687 certifica ading p	lan/	23b. Was decedent pregnant in the past 12 months?	1 Live birth Pregnant at t		2 Feta	I death 3	Ectopic	pregnancy	Į.	Month	Day	Year
Box te death the atter	Physician/	1 Yes 2 No 9 Unkno	• —	ine or death	5 Othe	er (Specify)	- 4					
ires that the signed by the detache	DA P	Part II. Other significant condition	s contributing to death	but not resu	Iting in the un	derlying cause	given in Par	rt I. 23e.		co use contribu	2	
ds, Faquires								1 24a	Yes 2			4 Unknown findings available
c law requir	Completed							- _	autopsy performed	prio d? dea	or to complete	tion of cause of
Vital Rec ysician: The l his certificate I		25. Was case referred to medical	T			26.Plac	e of Death (Check only one)	Yes 2]No 1	Yes	2 No
Vita	To Be	examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpatien		VOutpatient		Other ₄	Nursing Home	5 Res	sidence 6	Other:	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi		27. Manner of Death 1 Natural 5 Pending		ar)	Bb. Time of Inj		ury at Work? Yes 2 🔀			injury occurred		
ivision or Atta after des I Directo din by the	Certification:	2 Accident Investig 3 Suicide 6 X Could n determi	not be 28e. Place of Inju		e, farm, street,		building, etc		ition (Stree	et and Number	or Rural Rou ilson	ute Number, City
Divis To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by		4 Homicide	ned (Specify) Sician: To the best of my			ed at the time.	late and plac	Gwyn	n Oal	c,MD.		
Fo the within 2 Fo the complet	Medical	one) 2 Medicai Examin	ner: On the basis of exam and manner stated.	ination and/o	or investigatio	n, in my opinio	n, death occ	curred at the time	, date and	place, and due	to the cause	e(s)
(2)	₹	29b. Signature and title of certifier	11			29c. Licens	se number M.E.	OCME		d. Date signed		y, Year)
1		30. I ame and address of person wh	no completed cause of de	ath (Item) 3	Me LD.	0.0.				ebruary 6, 2	2012	
8	1	Theodore M. King, Jr., N				00 W. Baltir	nore Stre	et, Baltimore	e, MD 2	1223		
St Regist		31. Date filed (Month, Day, Year) FEB 1 0 2012	32. Registrar	Signature	haves							
r (og i o	بالند	1 2 0 2012	- Comment	- 17	** **							

Hashem Aryamar		1- For State Registrar		of Maryla		artment o ertificate of			d Menta	al Hy		Reg. No.	20	12	037	13
Physiciai Medical Examin	n/	1. Decedent's Name (Hashem		esh						2	2. Date of Dea Month February	Dav	Year 2	3.	Time of Death 1130 hrs	
		4a. Facility Name (if n 7304 Riggs R		street and nun	nber)		-	Town, or I	ocation of	Death		4c	County of De			
Funeral Director		5. Social Security Num	566 1 ∑ ≀	И 2 F	7. Age (In yrs. 6 2		Mon	der 1 Year ths Days	if Under Hours	24Hrs. Min.	8. Date of B		950	reign	ace (State or ry) Iran	
ne Maryiand or 28a-f show any fred at once.	<u>آ</u>	MD	b. County Prince	George		, Town or Locat vattsvi	116							1	od. Inside City L	
h the Mary 3a or 28a 10tified at	I Director	10e. Street and Numb	ggs Roa				2	ip Code 20783					zen of What 0			
	by Funeral	11. Marital Status 1 X Never Married 3 Widowed	2 Married	12. Was Dece Armed For 1 Yes Yes, Give Year or Dates:	dent Ever in U ces? 2 X No		es, spec		Mexican, F		cify Yes or No ican, etc.)		14. Race - Ar White, etc Specify:	C.	ite	
D36 thin 72 hours : ne. than "naturi	Completed b	15. Decedent's Educ Elementary/Second			4 or 5+)		ost of w		DO NOT us				ind of Busine		_{lstry} tation	
MD 21215-0036 d 2 should be filed within 7 lith and Mental Hygiene. n 27 is marked other than unmatic event, the Medica	8	17. Father's Name (Fin Ali Aryan 19a. Informant's Name	manesh	oo Print)		19h Mailing	Addres		Azra	ı Ze	raat	Doc		toto 7i	n Cado)	
B, MD 2 and 2 shoul Health and N item 27 is n		Susan A:	ryamane	sh s		5090	Li	ck M	ill	Blv		20	-	ıta	Clara	CA
Baltimore, permit. Pages I ar Department of Hea Important: If itei injury or other tr		1 N Burial 2 4 Donation 5 21. Signature of Funer	Other Specify:			crematory or oth hesht	Zah	ira			/2012 plici		Iran Crem	& :	Fun Se	rv
Physician	-	Thomas Allen PA 7090 Ridge Rd Hand 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												OVET M Approximate Intel Between Onset Death	erval	
Examiner		Immediate Cause (Fin or condition resulting in Sequentially list conditions)	in death) Do	sphyxia ue to (or as a o anging	consequence o	of):										
	Examiner	if any, leading to immediate. Enter Underlyi (Disease or injury that events resulting in dea	ediate De ing Cause t initiated c.		consequence c											
execu	edical E	UNPENDED	d	AMENDED										+		
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri	2 I	IF FEMALE: 23b, Was decedent pre past 12 months? 1 Yes 2 No	_	1 Live bir	nt at time of de	2 Fe	tal death	_	Ectopic p	pregnand	ey		. Date of deliv	very Day	Year	
ords, P.O. E w requires that the d is been signed by the should be detached	≦	Part II. Other significa	ant conditions	ontributing to	death but not r	resulting in the u	nderlyin	ng cause gi	ven in Part	I.	l				cause of death?	
Division of Vital Records, P.O. ral or Attending Physician: The law requires that the all prince and the state of the After this certificate has been signed by led in by the funeral director, page 2 should be detacted.	Completed										1 Yes		prior death	to com	sy findings avail pletion of cause 2 \to No	of
Vital hysician: this certial director	9 Re	25. Was case referred examiner? 1 ✓ Yes 2		spital: 1 In	patient 2	ER/Outpatient	3		of Death (C Other 4 N			Resider	nce 6 🗹 Ot	ther: So	ene	=3
sion of trending Ph death. ctor: After if y the funeral		27. Manner of Death 1 Natural 5 2 Accident	Pending		Day,Year)	28b. Time of In FOUND: 1115 hrs		1 Y	at Work? es 2 ✔ N	lo S	Bd. Describe ubject har	nged s	elf			
Divis Hospital or A 24 hours after Funeral Dire tely filled in b	Certification:	3 Suicide 6 4 Homicide 29a. Certifier	Could not be determined	(Specify)	Multi-Fami					73	or Town, \$ 304 Riggs R	State) load Ap	t. 101, Hyat	tsville	Route Number,	Dity
To the Host within 24 host of the Fun completely it		(Check only one) 2 Me			examination a		ion, in m	ny opinion,	death occu			and plac	ce, and due to	the ca		
		29b. Signature and title	ح د				29	O.C.N					oate signed (i		∪ay, Year)	
4		30. Name and address Ling Li, MD		dical Exam	iner 900	W. Baltimor	e Stre	et, Baltir	more, Mi	D 212	23					
Sta Registra													· · · · ·			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 7 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 4:47p Nicholas J. Blasetti Feb.7, 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Stella Maris Hospice Towson Baltimore 8. Date of Birth Sept. 3, 1927 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Director PΑ 217-22-0667 84 Yrs 1 3 M 2 F Usual Residence of Decedent or 28a-f show notified at 10a. State 10b Count 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Essex 1 Yes 2 X No 9 10e. Street and Numbe 10f. Zip Code 10g, Citizen of What Country? ral", or items 23a or Examiner must be r Funeral 1170 Foxwood Lane 21221 USA item 27 is marked other than "natural", or items other traumatic event, the Medical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian, Armed Forces þ 1 Never Married 2 Married Yes f Yes, Give 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify 3 XWidowed 4 Divorced White Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry 4:47 (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Beth Steel Railroad Tech nd 2 should be filed with salth and Mental Hygien n 27 is marked other tl 6th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Samual S. Blasetti Bella A. Basile 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jens I and I amount of Heak I mportant: If item 2; any injury or other transcript. Virginia Fennelly/daughter 1170 Foxwood Lane Baltimroe MD 21221 FEBRUARY 20a Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1x Burial 2 ☐ Cremation 3 ☐ Removal from State SacredHeartofJesus 2/13/12 Baltimroe MD Donation 5 Other (Specify) 21. Signature Fineral Service Licensee 22. Name and Address of Facility 300 MAce Ave. Balto. MD Connelly Funeral Home of Essex 21221 Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition resulting in death) ASPIRATION PNEUMONIA Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) and that initiated events resulting in death) Last Due to (or as a consequence of): physician a s the burial-Physician/Medical Box 68760 NICHOLAS BLASETTI as the attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 Yes 2 No Month Year Pregnant at time of death Day 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 Unknown Records, P.O. signed by Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has performe Yes 2 X No 2 🗆 No 1 Yes Division of Vital the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 1 Yes 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 X Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred After (Month, Day, Year) 1 X Natural injury 5 Pendina work 124 hours after death. The Funeral Director: Alphately filled in by the fi 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, determined building, etc. (Specify) 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 To the F X Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and 29d. Date signed (Month, Day, Year,

Registrar

DHMH 17 Rev 06-2011

State

30. Name and add

JACKIE JONES.

31. Date FEB 1, 0 2012

TIMONIUM, MD 21093

2300 DULANEY VALLEY RD.

of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ February ADELINE OGIER BRACKEN 2012 9:45A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Baltimore 2525 Pot Spring Road #609 Timonium 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Days Months Hours 09/08/1915 Maryland **Director** 1 - M 2 XX 216-56-9007 96 Usual Residence of Decedent show 10a. State 10d. Inside City Limits the Maryland at 10c. City, Town or Location Director notified 28a-f 1 ☐ Yes 2**XX** No Maryland Baltimore Timonium 10e. Street and Number 10f, Zip Code ō 10g. Citizen of What Country? ms 23a or must be i Funeral 21093 USA 2525 Pot Spring Road #609 permit. Page 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, "natural", or iten Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 XXNo Specify: If Yes, Give Year or Dates Specify. Completed 3XX Widowed 4 ☐ Divorced White 27 is marked other than "natur traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Elizabeth Ballard Herbert Leakin Ogier 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1804 Snow Meadow Lane # 301 Baltimore, Maryland 21209 Mary E. Neale DTR Department of Health Important: If item 27 any injury or other tronge. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 XX Burial 2 Cremation 3 Removal from State 02/11/2012 New Cathedral Cemetery Baltimore, Maryland Donation 5 Other (Specify) onature of Fun S 22. Name and Address of PMitchell-Wiedefeld Funeral Home Inc 6500 York Road Baltimore, Maryland 21212 23a. Part 1. Enter the disease, or complice shock, or heart failure. List only one ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Failure Congestive Heast Physician/ 205 Medical Due to (or as a lonsequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last for use as the burial-trait Due to (or as a consequence of) physician Hospital or Attending Physician: The law requires that the death certificate be to 24 hours after death.

Funeral Director: After this certificate has have some strand to the strand to Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Dav 4 ☐ Pregnant at time of death g ☐ Unknown Year 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Fibrillation 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Was an autopsy performed? 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ပ္ 1 Inpatient 2 ER/Outpatient 3 IDOA within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral a 27. Manne of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred ■ Natural injury 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of ce 29d. Date signed (Month, Day, Year)

2

31. Date filed (Month, Day, Year) State Registrar

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

William D. McConnell 6301 North Charles Street Baltimore MD 21212

				For State o		artment of Heal	th and Mental Hy	21117	2 03742
	ľ	Physicia	n/	Decedent's Name (First, Middle, Last) Ruth Ann Bond		Timodio o. Dod	2. Date of De		3. Time of Death
		Medic Examin	al	4a. Facility Name (if not institution, give street and num	ber)	4b. City, Town, or Local	tion of Death	06 2012 4c. County of Deat	1:30 P M
		<i>k</i>	ш	Stella Maris 5. Social Security Number 6. Sex	7.0	Timonium If Under 1 Year If Un	nder 24 Hrs. 8 Date of Bir	Baltimor	
		Funeral Director		218-44-5473	7. Age (In yrs. last birthday) 67 Yrs.	Months Days Hou	urs Min. (Month, Da	y, Year) Co	thplace (State or Foreign untry)
		nd how at	'n	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	ocation	12/08/	1944 Bal	t., MD 10d. Inside City Limits
		Maryla 28a-f otified	irect	MD Harford	Bel Air				1 ☐ Yes 2 No
		n with the	Funeral Director	10e. Street and Number 1237 St. Francis Road		10f. Zip Code 21014		10g. Citizen of What Co	ountry?
p.m.	3036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decer Armed For 1 Yes, Given Year or Da	2 XNo	Was Decedent of Hispanio If Yes, specify Cuban, Me 1 ☐ Yes 2 🛣 No Spe	c Origin? (Specify Yes or No- xican, Puerto Rican, etc.) ecify:		
1:32	21215-0036	within 72 hor giene. er than "nat the Medica	Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-	(Give life, D	dent's Usual Occupation kind of work done during O NOT use retired) memaker	most of working	16b. Kind of Business/ Own Home	'Indu <i>s</i> try
	Maryland	d be filed Mental Hy, arked oth	To Be	17. Father's Name (First, Middle, Last) Arthur G. Foard		18. N Ha	Mother's Name <i>(First, Middle,</i> anna R. Shann	Maiden Surname) On	
	Man	d 2 shoul alth and I 27 is ma er trauma	4	19a. Informant's Name/Relationship (Type, Print) Edward Bond - Spouse			umber or Rural Route Numbe s Road, Bel A		
JARY	Baltimore,	age 1 and ent of Hea it; If item y or othe	8	20a. Method of Disposition 1 ☑ B@ial 2 ☐ Cremation 3 ☐ Removal from 4 ☐ Ponation 5 ☐ Other (Specify)	State 20b. Place of Dispo cemetery, crei	matory or other place)	Date	20c. Location - City or	
FEBRUARY	Baltir	permit. Pa Departme Importan any injur		21. Signature of Euneral Service Licensee		2. Name and Address of F	2/11/2012 acility Schimunek	Funeral Ho	me of BelAir
٦				23a. Part 1. Enter the disease, or complications that c shock, or heart failure. List only one cause on ear	aused the death. Do not ent		ail Rd. Bel A		Approximate
	. wile	Physician/	9 9	Immediate Cause (Final disease or condition	TAGE MULTIPLE	SCLEROSIS			Interval Between Onset and Death
١		Medical Examiner		Due to (c	or as a consequence of):				
J	D.T.	ed isit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	or as a consequence of):				
		be executed sician and burial-transi	al Exa	that initiated events C	or as a consequence of):				
	1760	certificate b nding physic use as the b	ledical	d					
	Вох	atte for	Physician/Me	in the past 12 months?	nant at time of death 5	Ectopic pregnancy Other (specify)		23d. Date of del Month	livery Day Year
	ls, P.O.	requires that the der been signed by the s should be detached	by	Part II. Other significant conditions contributing to de	ath but not resulting in the u	underlying cause given in l	Part I. 23e. Did to	obacco use contribute to	the cause of death?
H BOND	Records,	The law requires cate has been sign, page 2 should by	Completed	14			24a. Was autor perfo 1 □ Yes	psy prior to o prmed? prior to o death?	topsy findings available completion of cause of
RUTH	Vital	rsician s certifi director	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital:	Inpatient 2 ER/Outpatie	Othors	Death (Check only one) Nursing Home 5 Resid	danas 6 V Oakas (Casa	4. HOCDTOR
•	n of	ding Phy h. After thi funeral		27. Manner of Death 1 X Natural 5 Pending 28a. Date of (Mont.)			28d. Describe h	now injury occurred	"y HUSFICE
	Division	l or Atten after deat Director: d in by the	Certificate:	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place buildin	of Injury - At home, farm, str g, etc. (Specify)			Street and Number or Rui vn, State)	ral Route Number,
1	_	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical	29a. Certifier (Check 2 Medical Examiner: On the basionly one) 3 X Certifying Nurse Practitioner:	s of examination and/or inves	tigation, in my opinion, dea	ath occurred at the time, date a	and place, and due to the o	cause(s) and manner stated.
4		To the within to the complex c		29b. Signature and title of certifier	19	29c. License numb	ber	29d. Date signed (Month	
•		10 gm		30. Name and address of person who completed cause	, , , , ,	Print)		-1-1	
ı		Stat	e	31. Date filed (Month, Day, Year) 32.	00 DULANEY VA	_	IMONIUM, MD 2	1093	
		Registra		FEB 1 0 2012 /2	was A. bu	ake			

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND ITEM#19a, perFH, G935, 1/30/2013, WS

State of Maryland / Department of Health and Mental Hygiene For State **Physician** Medica Examine 36 2 Funeral Director 02100/10/1 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. Baltimore, Maryland 21215-0036 Belton, Ernestine Physician/ Medical Examiner Medical Certificate: To Be Completed by Physician/Medical Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760

-	1 - For State Registrar	Otate of Maryli	•	tificate c					i.20	12	03743
,	1. Decedent's Name (First, Middle, Las	_	1.		-		2. Date of De	ath			3. Time of Death
•	Ernestine Aj 4a. Facility Name (if not institution, give		elton .	4h City Taw	n, or Location of		January				0036 A M
	Shady Grove Adve	· ·			ville	or Death		4	c. County Mon	of Death tgome	ery
	5. Social Security Number 6. S 228-34-0338 1		s. last birthday)	If Under 1 Y Months Da	ear If Under ays Hours	24 Hrs. Min.	8. Date of Bir (Month, Da			9. Birth	place (State or Foreign
	Usual Residence of Decedent	□ M 2 🗓 F 80	Yrs.			1	Mar. 2,	19	31	Virg	ginia
	10a. State 10b. County	10c.	City, Town or Lo	cation							Od. Inside City Limits
	VA 10e. Street and Number	R	ichmond	10f. Zip Coo	10	-		10 0	222	4/1 - 4 0	1X Yes 2 No
3	8610 Burgundy Ro	ad		2323				10g. C	Citizen of V USA		ntry?
= H	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13. V		of Hispanic Orig Suban, Mexican	gin? (Spec	ify Yes or No-		14. Rac	e - Americ	an Indian,
2	1 Never Married 2 Married 3 Widowed 4 Moivorced	1 Yes 2 No If Yes, Give Year or Dates.			No Specify:		iodii, oto.j			ck, White, Bla	
Paradillo	15. Decedent's E (Specify only highest gra	ducation	16a. Deced	lent's Usual Oc	cupation	t of secondary	_	16b.	Kind of Bu	usiness/In	dustry
	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do	ONOTuseretii rse's A	/	: or working	9	,		. 1	
<u> </u>	12 17. Father's Name (First, Middle, Last)		Nu.	ise s A	1 /	er's Name	(First, Middle,		Hospi		
: [James William Jer	man					o Jorda			-7	
	19a. Informant's Name/Relationship (T) Ernestine Harri	ype, Print)	19b. Mailin	g Address (Str	eet and Numbe	r or Rural	Route Numbe	r, City o	or Town, S	State, Zip 0	Code)
1	Ernestine Darric 20a. Method of Disposition	-Daughter	8610 D. Place of Dispos		dy Road		chmond			235	Chata
	1 Surial 2 Cremation 3 4 Donation 5 Other (Specif	Removal from State F	cemetery, crem	natory or other Naturn	place)	ا2–3–2			Location - chmon	-	
1	21. Signature of Hineral Service Lice		emetery 22	. Name and Ad	dress of Facility	Met	ropolit	an	Fune	ral S	Service
4	X Jenn ()	mume)))	ol/ Vin	e Stree	t, A.	Lexandi	cia,	Vir	ginia	a 22310
	23a. Part 1. Enter the disease, or comp shock, or heart failure. List only or Immediate Cause (Final	ne cause on each line.						est,			Approximate Interval Between Onset and Death
1	disease or condition resulting in death)	a. Myo Co-	rdial	Y	ntarc	からか	<u>~</u>			V	ninutes
1	Sequentially list conditions,	b									
-	if any, leading to immediate cause. Enter Underlying	Due to (or as a conse	equence of):							7-3	
	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a conse	equence of):							-	
1		d									
	IF FEMALE:	000 16 100 100 100 100 100 100 100 100 1									
ľ	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of preg 1 ☐ Live Birth 2 ☐ For 4 ☐ Pregnant at time of	etal death 3	Ectopic pregn					23d. Dat Mor	e of delive	ery Day Year
	9 🗌 Unknown	9 🗌 Unknown									
ا ،	Part II. Other significant conditions co	ontributing to death but not r	resulting in the ur	nderlying cause	given in Part I.				,		e cause of death?
											pably 4 Unknown
								sy med?	p	rior to cor leath?	osy findings available mpletion of cause of
1	25. Was case referred to medical examiner?	-		26	. Place of Deatl	h (Check o	1 \(\sum \) Yes	2 4	lo 1	Yes	2 🗌 No
	1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 [Talle en un		e 5 🗆 Resid	ence	6 □ Othe	r (Specify)	
2	27. Manner of Death 1 Natural 5 Pending	28a. Date of injury (Month, Day, Year)	28b. Time of injury	W	njury at ork? Yes 2		ld. Describe h	ow inju	ry occurre	•d	
ı	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At	home, farm, stre				Bf. Location (S	treet ar	nd Numbe	r or Ru r al	Route Number,
		building, etc. (Spec					City or Tow				
	(Check 2 L. Medical Examir	sician: To the best of my kno ner: On the basis of examinat the Practitioner: To the best o	ion and/or investi-	gation, in my or	pinion death occ	curred at th	e time date ar	nd place	and due	to the call	ea/e) and manner stated
2	29b. Signature and title of certifier			29c. Lice	nse number			29d. Da	ate signed	(Month, E	
	· Cyll	an a	10	04	143	10		JAL	SUARY	127	2012
3		one mb	em 23a) (Type, Pr 9901 M	int) Vedica	143 °	Dr	Rock	VI	ر عاا	ND.	20450
3	FEB 1 0 2012	32. Registrar's Sign	nature	1					- /		
1	- Z V LVIL	WHONE G.	LE CASES								

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 03744 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Carlton Chase 10:45 A^M 2012 02 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Bethesda Nursing & Rehabilitation Bethesda Montgomery 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Days Hours Min. Director 579-66-0133 07/27/1949 Washington DC Usual Residence of Decedent show 10a. State 10b. County r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10d. Inside City Limits Director 10c. City, Town or Location 1X Yes 2 □ No DC Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20003 900 5th Street, SE USA 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces? 1976 Black White etc þ 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 1977 Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) 10th within 7 College (1-4 or 5+) Private Security Guard ulth and Mental Hygie 27 is marked other r traumatic event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည be 1 Juanita Weldon permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marken any injury or other traumatic e Alvin Chase 19a. Informant's Name/Relationship (Type, Pnint) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carlton Thompson (Son) 4600 Muscoti Way, Bowie MD 20720 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 XCremation 3 Removal from State 4 Donation 5 Other (Specify) 2/8/2012 Hanover, MD Cremation Signature of Funeral Service License 22. Name and Address of Facility Latimore Funeral Services, PA 2818 E. Baltimore Street, Baltimore MD 21224 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ sclenobenma disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): the attending physician and hed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Be Completed by Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death

9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Dav 1 Yes 2 Unknown n signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 PNo 3 ☐ Probably 4 ☐ Unknown this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 **2**00 Yes 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 🗷 No ၉ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 5 Pending within 24 hours after death.

To the Funeral Director: A ☐ Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Gertifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Gertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 217112 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Grosvenor Lane, Bethesda Md 20814 0 Baro MD Troung

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Bay, Year)

Maryland 21215-0036

Baltimore,

Box 68760

P.O.

Division of Vital Records.

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene **1 – For** State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year Lillian Carter 11:43 8 bruary Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Seasons Hospice Randallstown 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Director 219-20-7130 Usual Residence of Decede 1 🗆 M 2 🗙 F 05/07/1920 Virginia 91 28a-f show or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21215 USA 3313 Avondale Avenue 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify. Specify: Black 3 XWidowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working should be filed within 72 and Mental Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Private 12th Nurse Be traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3313 Avondale Avenue, Baltimore MD 21215 permit. Page 1 and 2 sh Department of Heatth ar Important: If item 27 is any injury or other trau Toney Snowden (Grandchild) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 🛛 Cremation 3 ☐ Removal from State 2/11/2012 4 ☐ Donation 5 ☐ Other (Specify) Ardent Cremation Hanover, MD 21. Signature Funeral Service Lider 22. Name and Address of Facility Latimore Funeral Services, PA 2818 E. Baltimore Street, Baltimore MD 21224 un 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final CENCI-Stage Onset and Death Al3heimers Ph_sician/ Rementin disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed nding physician and use as the burial-tran Due to (or as a consequence of) nding physician Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) for in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death signed by the a P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? After this certificate 2 🗌 No 1 🗌 Yes Yes within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director, Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 No 1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) . Manner of Death 28b. Time of 28c. Injury at work? Certificate: 1 Natural 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 3 29b. Signature and title of certifie 29c. License number 2 29d. Date signed (Month, Day, Year)

State Registrar W.S. Ruppuhulmir

NS Rajpaksemb

32. Registrar Signat

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

81 V D GKN BUMIC MD 21061

00057465

2/10/12

		State of Maryland / Dep		/lental Hygien		271.6
		Registrar 1. Decedent's Name (First, Middle, Last)	rtificate of Death	Reg. N	10. C O 1 L O	3/40
Physicia Medic		Yong Kwan Choi		Feb. 02		e of Death
Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	1	c. County of Death	
		Randolph Hills Nursing Home 5. Social Security Number 6. Sex, 7. Age (in yrs. last birthday)	Silver Spring If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Montgomery 9. Birthplace (Sta	to as Faraign
Funeral Director		5. Social Security Number $ \begin{array}{ccccccccccccccccccccccccccccccccccc$	Months Days Hours Min.	09/25/1930	Country) Korea	te of Foreign
nd now	ŗ.	Usual Residence of Decedent 10a, State 10b, County 10c, City, Town or Lo	ocation		10d Insid	e City Limits
/arylar 8a-f st	Director	10a. State MD 10b. County 10c. City, Town or Lo	ring			Yes 2 No
th the N 3a or 2 t be no	ral Dii	10e, Street and Number	10f. Zip Code 20904	10g. (Citizen of What Country?	
eath w ems 2 er mus	Funeral		Was Decedent of Hispanic Origin? (Spe	ecify Yes or No-	14, Race - American Indian	1,
36 after de I", or il	by		If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☑ No Specify:	Rican, etc.)	Black, White, etc. Specify: Asian	
hours	lete	15. Decedent's Education 16a. Dece	dent's Usual Occupation	16b.	Kind of Business Industry	
215 nin 72 ne. than "r e Med	Completed	Elementary/Seconday (0-12) College (1-4 or 5+)	kind of work done during most of work DO NOT use retired)	ing	nstruction	
d 21 Hygier Sht. th	Be C	17. Father's Name (First, Middle, Last)		e (First, Middle, Maide		
ylan	2		Unk	o (r rrott, rradio, rradio	1	Unk
Maryland 21215-0036 12 should be filed within 72 hours after aith and Mental Hygiene. 127 is marked other than "natural", or r traumatic event, the Medical Exam			ing Address (Street and Number or Rura eatherwood Ct. #21			4
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		I Dullar 2/23/Oremation 3 Li Removal nom State	matory or other place) U2/U	o,	Location - City or Town, State	e
Baltin permit. Pa Departme Importan any injun			2. Name and Address of FaciliRapp	Funeral &	Cremation Se	rvices
a a a a a a		Pleacea Hackeimon 19	33 Gist Ave. Sil			
Physician/	54 7	23a. Part 1. Enter the disease, or complications that caused the death. Do not enshock, or heart failure. List only one cause on each line. Immediate Cause (Final Pneumonia	er the mode of dying, such as cardiac of	or respiratory arrest,		mate Between nd Death
Medical Examiner		disease or condition resulting in death) a. Due to (or as a consequence of):				
<i>d</i> +	iner	Sequentially list conditions, if any leading to mind data cause. Enter Underlying				
xecuteo	Examiner	Cause (Disease or linjury that initiated events c. Due to (or as a consequence of):				
60 ate be enthysician	dical	d				
587(ertificat ding ph	/Me	IF FEMALE: 23b Max decedent program 23b Max decedent program 23c If yes, outcome of pregnancy				
Sox (death ce e attence id for us	Physician/Medical	in the past 12 months? 1	Control of the contr		23d. Date of delivery Month Day	Year
at the c	Phy	9 Unknown Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco	use contribute to the cause	of death?
ords, P.O. Box 68760 requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	ted by	Alzheimer's Disease			2 ☐ No 3 ☐ Probably 4	
Division of Vital Records, P.O. Box 68760 Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Funeral Director: After this certificate has been signed by the attending physician and eted filled in by the funeral director, page 2 should be detached for use as the burial-transit	Completed			24a. Was an autopsy performed?	24b. Were autopsy findin prior to completion death?	
/ital Reco	Be Co	25. Was case referred to medical	26. Place of Death (Check	1 \(\text{Yes} 2 \)	No 1 Yes 2 No	
f Vita Physicia this cer al direct	To B	examiner? 1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie	ent 3 DOA Other: 4 Nursing Ho	ome 5 Residence	6 ☐ Other (Specify)	
n of ding Pl h. After th funera		27. Manner of Death 1 № Natural 5 □ Pending 2 □ Accident Investigation 28a. Date of injury (Month, Day, Year) injury	of 28c. Injury at work? M 1 □ Yes 2 □ No	28d. Describe how inju	ury occurred	
Division of all or Attending P s after death. I Director: After t all in by the funeral	Certificate:	2 Accident Investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)		28f. Location (Street a City or Town, Star	and Number or Rural Route No	umber,
Div Hospital or 24 hours aft Funeral Dir leted filled in		29a. Certifier 1 - Certifying Physician: To the best of my knowledge, death	occured at the time, date and place, as			
he Hos in 24 h he Fun ipleted	Medical	(Check 2 Medical Examiner: On the basis of examination and/or inveronly one) 3 Certifying Nurse Practioner: To the best of my knowledge,	stigation, in my opinion, death occurred a	t the time, date and place	ce, and due to the cause(s) and	I manner stated.
To the within 2 To the Complete		29b. Signature and title of certifier	29c. License number D52261		ate signed (Month, Day, Year))
		30. Name and address of person who completed cause of death (Item 23a) (Type,	Print)			
2			ilver Spring, MD 2	.0906		
Stat Registra	e ar	31. Date filed (Month, Day, Year) 7 2012 32. egistrer's Signature 3.	ale			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#5perFH, G924, 2/28/2012, WS
State of Maryland / Department of Health and Mental Hygiene 20 | 2 for State Registrar Certificate of Death 2. Date of Death 3. Time of Death Physician/ February 1:50 AM 2012 thorne Medical 4b. City, Town, or Location of Death itution, give street and number) **Examiner** Himore limonium Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) If Under If Under 24 Hrs **Funeral** Hours **Director** M 2 □ F 28a-f shov Ellicott 10d. Inside City Limits Director must be notified 1 Yes 2 No 10g. Citizen of What Country? 21228 Funeral USA items 23a rooked 12. Was Decedent Ever in U.S. Armed Forces?

1 ✓ Yes 2 ☐ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examiner Black, White, etc. þ 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 Yes 2 No Black Completed 3 Divorced 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working life. DO NO 11st retired) Elementary/Secondary (0-12) years Be 2 athorne rooka Nite Method of Disposition 20b, Place of Disposition (Name of ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) nature of Funeral Service 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition resulting in death) END STAGE CARDIAC DISEASE Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to for as a consequence of, the Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of death? 1 Tes 2 No 2 **X** No Yes Be (25. Was case referred to medical examiner? Division of Vital 26. Place of Death (Check only one) Hospital Other: 1 Yes 2 X No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 X Other (Specify) HOSPICE 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work? 1 \sum Yes 2 \sum No injury 1 X Natural 5 Pendina Accident Investigation Suicide 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. X Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature a 29c. License number 29d. Date signed (Month, Day, Year) of person who completed cause of death (Item 23a) (Type, Print) JONES, 2300 DULANEY VALLEY RD. CRNP MD 21093 31. Date filed (Month, Day, Year, 32. Registrar's Signature State Registrar

2012

KOLAND

State of Maryland / Department of Health and Mental Hygieney For State Registrar Certificate of Death 3. Time of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) Month 2012 **Physician** 7:54 p. M Moses Manchame Cabrera February 43 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner Takoma Park Montgomery Washington Adventist Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yeer) 02/04/2012 Birthplace (Stete or Foreign Country) 7. Age (In yrs. last birthdey) 6. Sex 5. Social Security Number **Funeral** Months **X**X M 2□ F Maryland Director (none) Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County ral', or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2\ZNo Hyattsville Prince Georges Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code with United States 20783 8003 15th St. #201 death Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2XXNo If Yes, Give 14. Race - American Indian, Black, White, etc. 1 and 2 should be filed within 72 hours after Health and Mental Hygiene. XXNever Married 2 Married Baltimore, Maryland 21215-0036 152 Yes 2□ No Specify: Guatemalan Specify: White If Yes, Give Year or Dates: þ 3 ☐ Widowed 4 ☐ Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) edical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry r then Elementary/Secondary (0-12) College (1-4or 5+) None None is marked other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Aura Cabrera Arnoldo Manchame ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 a Department of Health ar Important: If item 27 is any injury or other trau once. 8003 15th St. #201, Hyattsville, Maryland 20783 (mother) Aura Cabrera 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Feb Dete 8. 1 Bunal 2 □ Cremation 3 □ Removal from State Silver Spring, MD. 2012 Gate of Heaven Cem. * 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Rapp Funeral & Cremation Service 21. Signature of Funeral Service Licensee 933 Gist Ave. Silver Spring, Maryland 20910 M00982 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Drematurit resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. physicien Physician/Medical the attending p 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No the detached 9 Unknown 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performe certificate 1 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 X Inpatient 2 2 ER/Outpatient 3□ DOA this 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: Alter 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No M 2 Accident hin 24 hours after death the Funeral Director: 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) within 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 2 D00710892 MD person who completed cause of death (Item 23a) (Type, Print) 30. Name and ad Spring Shed Suite 220 Silver Spring Rudesil MO \mathcal{W} MD FEB 1 0 2012 32. Registrar's Signature State Registrar arks

DHMH 17 Rev 1/2001

			Pleas	se Type or Pr	int in	Black In	ndelible In	k. Ensı	ıre A	II Copie	s Ar	e Legi	ble.		
		For State		State of M	larylan		artment of I		and M	lental Hy	/gien	e 20	12	n s	374
		Registrar 1. Decedent's Name	e (Eirst Middle	(act)		Cei	tificate of L	Death		0.01.40	Reg. N	lo. 2 U	1 4		-
Physicia				,	ry, S	tr				2. Date of De Month Februa		4, 20	Year	3. Time 11:4	of Death
Medic Examir				give street and number)	<u> </u>	, <u> </u>	4b. City, Town, o	r Location o	f Death	reprue		c. County of		11.5	<u> </u>
		3429 Mc(1111111111					hvill∈				Harfo	rd		
Funeral Director		5. Social Security No. 218–28–43 Usual Residence of	343	5. Sex 7. Ag	ge (In yrs. I 81	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min.	8. Date of Bit (Month, Date 06/16/		0 1	9. Birthp Cou <i>nt</i> Mary	rv)	e or Foreigr
and show	ō	10a. State	10b. County		10c. Cit	y, Town or Lo	cation	11					10	d. Inside	City Limits
Maryl 28a-f otifiec	Director	Maryland	Han	ford		C	hurchvil	le						1 🗆 Y	es 2X No
th the 3a or t be n	aD	10e. Street and Nun					10f. Zip Code	4000			10g. C	Citizen of W		ry?	
ath wi ems 2 r mus	Funeral	11. Marital Status	29 MCCOR	mons Road 12. Was Decedent	Ever in U.S	3 13 1	Vas Decedent of H	1028	in? (Spec	cify Yes or No-		US 14. Race		n Indian	
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	by	1 ☐ Never Marri 3 ☐ Widowed		Armed Forces?			f Yes, specify Cuba	an, Mexican,					, White, e	tc.	
2 hou "natu	plet	(Spe	15. Decedent	's Education grade completed)		16a. Deced	lent's Usual Occup	ation	of workir	na	16b.	Kind of Bus	siness/Ind	ustry	
tthin 7 ene. • than he Me	Completed	Elementary/Seco		College (1-4 or	5+)	life. D	O NOT use retired) er Woodc			.9	US	Gove	rnmer	n t	
iled will Hygid other	Be	17. Father's Name (#		st)		Plast	er woode.			(First, Middle,					
d be fi	မ	Charle	es M.	Curry				Mar	_	Dudeck		, ,			
shoull and ? is ma		19a. Informant's Na	me/Relationship	(Type, Print)		19b. Mailir	ig Address (Street	and Number	or Rural	Route Numbe	er, City c	or Town, Sta	ate, Zip C	ode)	
and 2 Health em 27 ther to		Terry Eas		laughter)	Tagy F		Aldino I	Road,		•					
age 1 ant of h		tx Burial 2 €	☐ Cremation 3	Removal from State	, С	emetery, cren	sition (Name of natory or other place	ce)		ate (2012		Location - (•		M
nit. Pa artme ortan injury		4 ☐ Donation 21. Signature of Fur	5 Other (Sp		ROC		Cemetery Name and Address			['] 2012		vre de			
Dep Imp any		Versi	endu	Les UNGl	esk	W/ A	. Name and Addres	Maryl	Tarr and	ng-Ca 21001	rgo	Fune	ral F	iome,	P.A
E CO		23a. Part 1. Enter to shock, or hear	he disease, or c	omplic tions that c wse	d the death	n. Do not ente	er the mode of dyin	g, such as c	ardiac or	respiratory a	rrest,			Approxim Interval B	
hysician/		Immediate Cause (I disease or conditio		a Color	L C	ance	R							Onset and	
Medical Examiner		resulting in death)		Due to (or as	a consequ	ence of):									
	Jer	Sequentially list con	nditions,	b. Due to (or as	a consequ	ence of):									
uted d ansit	Examiner	cause. Enter Under Cause (Disease or i that initiated events	rlying injury												
e executed vian and urial-transit		resulting in death) L		Due to (or as	a consequ	ence of):								-	
ate be hysici the bu	dica			d	*****								_		
ding p	/Me	IF FEMALE:		23c. If yes, outcome	of pregna	ncv									
To the hospital or Afterding Physician: The law requires that the death certificate be within 24 hours after death. Within 24 hours after death. Within 24 hours after death. Completely filled in by the funeral director, page 2 should be detached for use as the by the after a street by the bound be detached for use as the bound be detached for use as the bound by the funeral director.	Physician/Medical	23b. Was decedent in the past 12 n 1 Yes 2 Unknown	months?		2 Feta	I death 3	Ectopic pregnand Other (specify)	У				23d. Date Mont		y Day	Year
s that gned b	by	Part II. Other signifi	icant condition	s contributing to death b	out not res	ulting in the u	nderlying cause giv	en in Part I.		23e. Did t	obacco	use contrib	oute to the	cause of	death?
equire een si	Completed									1 🗆	Yes 2	2 □ No 3	Proba	ably 1	Unknown
has b	mple									24a. Was auto	psy	pri		sy findings pletion of	available cause of
n: Ihe ficate or, pag	e Co	25. Was case referre	ed to medical	1				45		1 Yes	rmed?	No 1	Yes 2	2 No	
ysicia s certi directi	To Be	examiner?	l No	Hospital:	ent 2 🗆	ER/Outpatien	Othe	er: 4 Nur		1	dones	6 Other	/C===i6.i		
ng Phy ter thi ineral		27. Manner of Death	5 Pending	28a. Date of inju	iry	28b. Time of injury	28c. Injury	y at		8d. Describe					
tendil Jeath. tor: Af the fu	Certificate	2 Accident 3 Suicide	Investiga	tion			M 1 🗆	Yes 2 1	No						
or At after of Direct I in by	Cert	4 Homicide	determin				et, factory, office		2	8f. Location (8 City or Tov			or Rural F	Route Nun	nber,
In the hoopstal or Attending Physician: The law within 24 hours after death. To the Funeral Director. After this certificate has completely filled in by the funeral director, page 2.	Medical	29a. Certifier	Certifying P	hysician: To the best of	my knowle	edge, death o	ccurred at the time	e, date and p	olace, and	d due to the c	ause(s) a	and manner	r as stated	d.	
in 24 lin 24 l he Fu Ipletel	Med	(Check 2	Medical Example 1	miner: On the basis of e urse Practitioner: To th	xamination	and/or invest	igation, in my opinio	on, death occ	urred at t	he time, date a	and place	e, and due to	o the caus	e(s) and m	anner state
Neit of		29b. Signature and t	itle of certifier	0 11			29c. License	number			29d. Da	ate signed (Month, Da	ay, Year)	
h		100	iliqu	an h	11)		1021	947	7		9	Ho	W	と と	
· *		30. Name and addre	ess of person wh	o completed cause of c	2005-	× 1.1	16.	DR O	di	Grade	> .	MD	214	28	
Stat Registra		31. Date filed (Month		2012 32. registr	ar's Signat	8. A	uki				,		•		_
				1											

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ February 2012ª Veronica C. Drozd 11:05 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Hospice of the Chesapeake Linthicum Heights Anne Arundel Funeral Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🗓 F 1171911918 Mary Land 212-01-3479 95 Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 ☐ No Maryland N/A Raltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 402 Imla Street 21224 United States 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Bace - American Indian. Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Completed by Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes. Give and Mental Hygiene. White 3XWidowed 4 ☐ Divorced Year or Dates injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Clothing Seamstress Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Thomas Helinski Sophia Sobus 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edward Tipton, Sr. - Cousin 112 3rd Avenue SW Glen Burnie, Maryland 21061 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ott Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 02/07/2012 4 ☐ Donation 5 ☐ Other (Specify) Stanislaus Cem. Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
David J. Weber Funeral Homes P.A.
401 S. Chester Street Baltimore, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. Lift only one cause on each line. Approximate Interval Between Demenha Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): Exami and I-transit death certificate be executed Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death Unknown P.O. signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à They person Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? cerebro rasular 24a. Was an autopsy 2 No ☐ Yes 2 No 25. Was case referred to medical examiner? Division of Vital 26. Place of Death (Check only one) Be Hospital 1 ☐ Yes 2 X No Other ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Hospital or Attending Natural Accident 5 Pending injury work?
1 Yes 2 No within 24 hours after death.

To the Funeral Director: After completed filled in by the fun Investigation ∟ Accider □ Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title 29d. Date signed (Month, Day, Year) りいそひ 02,03,2012

Registrar DHMH 17 Rev 7/2009 1406

31. Date filed (Month FEB

crain

Box

marchodynami

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Dignan, Dorothy 2/8/12 526AM Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

	, widale, Lastj							
	othy Mary Digna	an			2. Date of Dea Month Feb .	08, 2012 Ye	ar 5:26 AM	
4a. Facility Name (if not ins	stitution, give street and number)		4b. City, Town, or	r Location of Death		4c. County of E		
0akcrest		4 1 7 1 1 1 1		ville I If Under 24 Hrs.	Table		ltimore	
Usual Residence of Deced	1 □ M 2 🟋 F	ge (In yrs. last birthda 96 Yrs.	Months Days	Hours Min.	8. Date of Birtl (Month, Day May 12,	1915 g.	Birthplace (State or Foreign Country) MD	
10a. State 10b. 0	County					_	10d. Inside City Limits	
MD B	altimore	Parkv					1 ☐ Yes 2 🛣 No	
8800 Walth	her Boulevard			234			t Country?	
11. Marital Status	12. Was Decedent		3. Was Decedent of H	ispanic Origin? (Sp		14. Race - A	American Indian,	
1 Never Married 2 Married 1 Yes 2 X No					Black, White, etc.			
3 X Widowed 4 □ D	Year or Dates.	16a De						
(Specify on	nly highest grade completed)	(Gi	ve kind of work done o		king	160. Kind of Busine	ess industry	
	12		Homemaker			Own Home		
		10h 84	alling Address (Ctreat				Zio Codel	
1						-	, <i>21</i> p Code)	
1 ☐ Burial 2 💢 Crei	emation 3 Removal from Stat	e cemetery, c	rematory or other plac		Date / 2012	20c. Location - City	•	
		ACTABLL		-				
300	Sweet				•	•		
	re. List only ohe cause on ea ch li ng. QSC	16. Ular Pen	4	g, such as cardiac	or respiratory arr	est,	Approximate Interval Between Onset and Death	
	c. Due to (or as							
	d							
23b. Was decedent pregna	s? 1 Live Birth 4 Pregnant	23c. If yes, outcome of pregnancy 1					23d. Date of delivery Month Day Year	
				•	23e. Did to	bacco use contribut	e to the cause of death?	
AZCVIJ,	HyperHASIVE	ardlo vax	War Disec	236	1 🗆 Y	res 2 No 3 E	Probably 4 Unknown	
					autop perfor	sy prior med? deat		
examiner?	Hospital:		Oth	er: 🖍				
27. Manner of Death	28a. Date of inj	ury 28b. Time	of 28c. Injun	4 Nursing H			pecify)	
2 Accident	Investigation	ay, Year) injur						
	dotorminad 28e. Place of Ir		street, factory, office				Rural Route Number,	
(Check 2 Me only one) 3 Ce	edical Examiner: On the basis of ertifying Nurse Practioner: To the	examination and/or inv	estigation, in my opinio	on, death occurred a	at the time, date ar	nd place, and due to	the cause(s) and manner stated	
29a. Certifier (Check 2 Medical Examiner: On the best of my knowledge, death only one) 3 Certifying Nurse Practioner: To the best of my knowledge, 29b. Signature and title Certifier						29d. Date signed (Mac 2/8/2017)	onth, Day, Year)	
30. Name and address of p	person who completed cause of 880	death (Item 23a) (Type	Blud Park	will. Mr	2/234	1-1		
	· · · · · · · · · · · · · · · · · · ·	4//////	UITUI IUII	SHILL IND				
31. Date filed (Month, Day,	3301100131		arles	7,11	1			
	10a. State MD B 10e. Street and Number 8800 Walt 11. Marital Status 1	MD Baltimore 10e. Street and Number 8800 Walther Boulevard 11. Marital Status 1	10b. County Baltimore Parkv	10c. State Number Baltimore Parkville 10c. City, Town or Location Parkville 10c. Street and Number 8800 Walther Boulevard 10c. City, Town or Location Parkville 10c. Street and Number 10c. Street and Number 10c. City, Town or Location Parkville 10c. Street and Number 10c. City, Town or Location Parkville 10c. City, Town or Location Parkville 10c. City, Town or Location Parkville 10c. City, Town or Location Parkville 10c. City, Town or Location Parkville 10c. City, Town or Location 10c. Ci	10b. County MD Baltimore Baltimore Baltimore Parkville	Journal Perfect and Number Security Se	Disc State Disc County Baltimore Disc City, Town or location Parkville Disc State Disc County Baltimore Disc State Disc County Disc Co	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Pebluar 2012 Physician/ 020 M MAYU Davis Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Arunder 10FTON 8. Date of Birth (Month, Day, You July 20 9. Birthplace (State or Foreign Country) 1927 Maryland If Under 1 Year If Under 24 Hrs. 5. Social Security Numbe 6. Sex 7. Age (In yrs. last birthday) **Funeral** Min. 1 🗆 M 2 🗓 F Months Days Hours 219-22-2216 Director 84 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 1 Yes 2X No MD Anne Arundel Crofton 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Numbe Funeral USA 21114 2131 Davidsonville Road Was Deceus Armed Forces? Ves 2 X No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. 1 Never Married 2 ☐ Married ģ 1 Yes 2X No Specify: If Yes, Give Year or Dates Specify: White Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) 12 College (1-4 or 5+) Restaurant Waitress Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Margaret Agnes Houlihan James Rubin Davis, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 677 Cog Court Millersville, MD 21108 19a. Informant's Name/Relationship (Type, Print) Peggy Marsh/daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crematory 02/10/12 Woodbine, MD 21. Signature of Funeral Service Lice Going Home Cremation Service P.O. Box 784 Heckrotte, P.A. MO1251 Beverly L. Clarksville, MD 21029 23a. Part 1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Pnysician/ disease or condition Medical resulting in death) Due to (or is a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to for as a consequence of Maranani that initiated events resulting in death) Last Due to (or as a consequence of): Medical Certificate: To Be Completed by Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23d. Date of delivery 23b. Was decedent pregnant funeral director,

Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Division of Vital Records, P.O. Box 68760 signed by the at d be detached for peen cate has certificate 24 hours after death. Funeral Director: After within 24 hours after dear To the Funeral Director completed filled in by the

Baltimore, Maryland 21215-0036

1 Yes 2 No 9 Unknown	4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown	Month Day rear				
Part II. Other significant conditions of	contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 💆 No 3 ☐ Probably 4 ☐ Unknown				
		24a. Was an autopsy performed? 1 □ Yes 2 No No 1 □ Yes 2 □ No				
25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑️ No	26. Place of Death (Check only one)					
	Hospital: 1 Inpatient 2 ER/Outpatient 3 DCA Other: 4 Nursing Home 5 Residence 6 Other (Specify)					
27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not b 4 Homicide determined	(<i>Month, Day, Year</i>) injury work? In M 1 ☐ Yes 2 ☐ No	3d. Describe how injury occurred				
	1 28e Place of Injury - At home farm Street Tactory office 1 28	28f. Location (Street and Number or Rural Route Number, City or Town, State)				
(Check 2. Medical Exam	vician: To the best of my knowledge, death occured at the time, date and place, and inner. On the basis of examination and/or investigation, in my opinion, death occurred at the se Practioner: To the best of my knowledge, death occurred at the time, date and place,	ne time, date and place, and due to the cause(s) and manner stated.				

29c. License number

29d. Date signed (Month, Day, Year)

State Registrar

the

31. Date filed (Month, Day, Year) 32. Registrar's Signature

Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ FEBRUARY 2012 9:09 AM JOSEPH ROY DUNAGAN Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MONTGOMERY NATIONAL INSTITUTES OF HEALTH BETHESDA If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex . Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral Country) Texas Days Hours Mar.6, 1976 1 X M 2 T F 228-51-0109 Director 35 Yrs Usual Residence of Decedent or 28a-f show notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 Yes 2 No VA Rappahannock Castleton 0 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be n Funeral 47 Scrabble Road 22716 USA items ? 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Examiner Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. ò þ 1 Never Married 2 K Married Maryland 21215-0036 White 1 ☐ Yes 2 🖾 No Specify: "natural" Specify. 3 Widowed 4 Divorced Completed Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. I other than " life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 2 Software Engineer Research/Investing Be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ith and Mental H 27 is marked of traumatic ever ည permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic tonce. Tony Morris Dunagan Fransi LaForge 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 22716 Amanda Dunagan/Wife Scrabble Rd., Castleton, VA Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State Fairview Cemetery Feb.11,2012 Culpeper, VA 4 Donation 5 Other (Specify) Found and Sons Funeral Chapels 22. Name and Address of Facility Signature of Funeral Service Licensee 850 Sperryville Pike, Culpeper, VA 22701 part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final 27 HOURS Physician/ HYPOXIA disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner 30 HOURS PULMONARY EDEMA Sequentially list conditions, Examine if any leading to immedicause. Enter Underlying Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Cause (Disease or linjury that initiated events 35 HOURS CAPILLARY LEAK SYNDROME and Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 the use as attending IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No for 5 Other (specify) Month Day Year Pregnant at time of death signed by the aid be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has autopsy performed' certificate 1 Yes 2 X No Yes 2 N 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Hospital Other: 4 \(\sum \) Nursing Home 5 \(\sum \) Residence 6 \(\sum \) Other (Specify) 2 🗶 No မှ 1 Yes 1 🗓 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA this 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) 1 X Natural 5 Pending injury s after death. 1 ☐ Yes 2 ☐ No Accident Investigation completed filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Medical 29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F only one) 3 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dav. Year) D0070874 MD FEBRUARY 3, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 CENTER DRIVE, BETHESDA, MARYLAND 20892 BRUCE FERNANDO SABATH 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

FEB

parks

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month February 2012 6:40 Howard Reeves Duley Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel <u> Anne Arundel Medical Center</u> Annapolis 8. Date of Birth Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Hours (Month, Day, Year) **Director** 578-56-8930 1 **X** M 2 □ F 69 07-13-1942 Washington, D.C. Usual Residence of Deced 28a-f show 10a, State 10d Inside City Limits at 10b. County 10c. City, Town or Location Director notified 1 Yes 2 X No MD Anne Arundel Gambrills 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 9 Examiner must be 23a Funeral 2313 Silver Way 21054 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🎇 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. an "natural", or Medical Examin þ 1 Never Married 2 X Married Saltimore, Maryland 21215-0036 1 Yes 2 X No Specify: If Yes, Give Year or Dates Specify: 3 Widowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 and Mental Hygiene. National Elementary/Secondary (0-12) College (1-4 or 5+) the Laboratory Technician 12 Geographic Society other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Howard Burton Duley Sophia Louise Reeves 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important; If item 27 is rany injury or other Sandra J. Duley / Wife 2313 Silver Way Gambrills, Maryland 21054 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 👿 Burial 2 🗆 Cremation 3 🗆 Removal from State ☐ Donation 5 ☐ Other (Specify) ft. Lincoln Cemetery 2-7-2012 Brentwood, Maryland Funeral Service Donaldson Funeral Home & Crematory, P.A Annapolis Road Odenton, Maryland 21113 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Ph_sician/ aridrovascula disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner fior. 116710 Sequentially list conditions, If any, leading to immediate cause. Enter Underlying Examin Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last physician Physician/Medical certificate be Box 68760 the as guipi IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No jo 5 Other (specify) Month Day Year Pregnant at time of death P.0. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed Yes 2 has page 2 certificate 1 Yes 2 No Division of Vital the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 1 No ည 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Director: After 5 Pending injury 1 Natural work? 1 ☐ Yes 2 ☐ No death. 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by hours after determined within 24 hours a Medical 29a. Certifier 1 🖵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 🗆 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year,

State Registrar

DHMH 17 Rev 06-2011

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signatus

HOOTUNE

2-3-12

			Please amend	Type or Print i items 2.4a State of Maryl	n Black In	delible li	nk. Ensure	All Copie	s Are Legil	ble.
		-	For State Registrar	State of Mary		tificate of		ivieritai i iy	Reg. No. 2	12 03755
H	Physicia	n/	1. Decedent's Name (First, Middle, Las					2. Date of De Month		Year
april 1	Medic Examin	al	4a. Facility Name (if not institution, give	street and number)	avi's	4b. City, Town,	or Location of Deat	1 2 h	4c. County o	f Death
)		5500 Ready	1237	and the state of the state of	Bal If Under 1 Yea	timore ar I if Under 24 Hrs		BA	City
B	Funeral Director		5. Social Security Number 6. S 061-46-9868 1	EX 7. Age (In y	rs. last birthday) Yrs.	Months Day		(Month, Da	iy, Year)	9. Birthplace (State or Foreign Country)
	and show d at	٦	Usual Residence of Decedent 10a. State 10b. County		. City, Town or Loc	ation		01-04	1-1437	10d. Inside City Limits
	e Maryla r 28a-f s notified	irecto	MD		BAUTI	MORE	7			1 Yes 2 □ No
	filed within 72 hours after death with the Maryland al Hygiene. 1 other than "natural", or items 23a or 28a-f sho vent, the Medical Examiner must be notified at	Funeral Director	10e. Street and Number	AVENUE		10f. Zip Code	1212		10g. Citizen of Wh	nat Country?
	leath w	Fune	11. Marital Status	12. Was Decedent Ever in Armed Forces?	n U.S. 13. W		f Hispanic Origin? (Suban, Mexican, Puer	pecify Yes or No-	14. Race	- American Indian,
36	all, or	d by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced	1 Yes 2 No If Yes, Give Year or Dates.		☐ Yes 2 🌠		,	Specify:	White, etc.
215-0036	2 hours aft "natural", edical Exa	Completed	15. Decedent's E (Specify only highest gr	ducation	16a. Deced	ent's Usual Occ ind of work don	upation e during most of wo	rking	16b. Kind of Bus	· •
2121	within 7 /giene. ner than t, the Me	Com	Elementary/Secondary (0-12)	College (1-4 or 5+)		NOT use retire	,		LEGAL	AIDE BUREAU
	e filed within 72 hour tal Hygiene. ed other than "natu event, the Medical	l o l	17. Father's Name (First, Middle, Last)	7 .			18. Mother's Na		, Maiden Surname)	
Maryland	2 should be filed wii th and Mental Hygie 27 is marked other traumatic event, the		JIDNEY THOMA 19a Informant's Name/Relationship (7)	S ZOLLICO		a Address (Stre	E VE L et and Number or Ru		YNCH er, City or Town, Sta	nte, Zip Code) Z0653
	1 and 2 sh of Health ar item 27 is other trau		TASHI DAVIS (SON)	4836		NBURST			PARK. MD
nore	0 = =		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Removal from State	Db. Place of Dispos cemetery, crem	atory or other p		Date 17/12	1	Dity or Town, State MORE, MD
Baltimore,	permit. Page Department Important: any injury conce.		4 ☐ Donation 5 ☐ Other (Special Signature of Function Service Licen	see	REENMT 22	Name and Add				FUNTERAL SCUS
B	o a m e	13	100.	NO/553	14	905 Y	ORK ROA	D. BAL	TIMORE,	MD.21212
	Physician/		23a. Part 1. Enter the disease, or comshock, or heart failure. List only of Immediate Cause (Final	ne cause on each line.		tille mode of d	ying, such as cardiac	or respiratory ar	11651,	Approximate Interval Between Onset and Death
	Medical Examiner		disease or condition resulting in death)	a. Due to (ot a) a con			intare	non		
		Jer	Sequentially list conditions, it is a sequentially list conditions, it is a sequentially list conditions, it is a sequentially list conditions, it is a sequentially list conditions, it is a sequentially list conditions, it is a sequentially list conditions, it is a sequentially list conditions, it is a sequentially list conditions, it is a sequentially list conditions, it is a sequentially list conditions, it is a sequentially list conditions.	b. Due to lor as a con	tes					+S years
	executed an and rial-transit	Examiner	Cause (Disease or injury that initiated events	· hype	tensio	0				+5 years
0		I = I	resulting in death) Last	Due to (et ds a con	,	incr	eatitis	_		+5 years
876	tificate ng phys	Medi	IF FEMALE:							3
Box 68760	ath cer attendi for use	Physician/Medica	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pre 1 Live Birth 2 4 Pregnant at time	Fetal death 3	Ectopic pregna Other (specify)			23d. Date Mon	of delivery th Day Year
	t the de by the	Physi	-	9 Unknown	A		ation in Doubl	1 00 000		
Division of Vital Records, P.O.	Attending Physician: The law requires that the death certificate be or death. ector: After this certificate has been signed by the attending physici by the funeral director, page 2 should be detached for use as the bu	d by	Part II. Other significant conditions of	ontributing to death but no	it resulting in the u	idenying cause	given in Part I.	23e. Did 1	F	bute to the cause of death? 3 Probably 4 Unknown
ord	iw requise been 2 shou	Completed by						24a. Was		ere autopsy findings available ior to completion of cause of
Rec	sician: The law certificate has t							1 Ves	ormed? de	eath?
Vital	ysician s certifi directo	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	2 ☐ ER/Outpatien	10	Place of Death (Che Other: 4 Nursing		idence 6 🗆 Other	(Specify)
l of	ling Physician: n. After this certific funeral director,		27. Manner of Death 1 Natural 5 □ Pending	28a. Date of injury (Month, Day, Yea	28b. Time of	28c. In w	jury at ork?		how injury occurred	
isior	Attending P er death. ector: After t by the funera	Certificate:	2 Accident Investigation 3 Suicide 6 Could not to 4 Homicide determined	28e. Place of Injury - A	At home, farm, stre		Yes 2 No			or Rural Route Number,
Div	Hospital or Atten 24 hours after deat Funeral Director: etely filled in by the			building, etc. (Sp			-	City or To		
	To the Hosp within 24 ho To the Fune completely f	Medical	(Check 2 Medical Exam	sician: To the best of my k iner: On the basis of examin se Practitioner: To the bes	nation and/or invest	igation, in my op	inion, death occurred	at the time, date	and place, and due	to the cause(s) and manner stated.
_	To the within 2 To the comple	_	29b. Signature and title of certifier		n (nse number	(,)	29d. Date signed	(Month, Day, Year)
)		30 Name and address of person who	completed cause of death	(Item 23a) (Type, P		0508	7 +	41	7112
)			301 85. Par	e Place	BA	, MO) 21	202		
7	Sta Registr	te ar	31. Date filed (Month, Day, Year) FEB 1 0 2	012 32. registrar's S	ignature.	ale				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. 2 Certificate of Death 1. Decedent's Name (First, Middle, Last, 2. Date of Death Day Physician/ Month Medical 4a. Facility Name (if not institution, give street and number) Town, or Location of Death Examiner 4c. County of Death Balto MD Turn brook 21234 If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 6. Sex 7. Age (In yrs. last birthday) Director 227-42-9085 1 🛛 M 2 🗆 F 73 04/06/1938 Virginia 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD Baltimore 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral U.S.A. 46 Turnbrook Court 21234 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces? þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: 3 ¥ Widowed 4 ☐ Divorced Completed Year or Dates White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Millwright Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 C. Castell W. Ruby James Dettor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nunley Dr., Apt. D, Baltimore, MD 21234 Gayle Dettor / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Anatany Gifts Registry 102/10/2012 Hanover, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Anatomy Gifts Registry 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Exami that the death certificate be executed and Due to (or as a consequence of): resulting in death) Last Physician/Medical 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery Box 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Pregnant at time of death ed by the a 2 No 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Hospital or Attending Physician: The law requires Records, 1 LYes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an nas autopsy this certificate 1 Yes 25. Was case referred to medical examiner? **Division of Vital** Be 26. Place of Death (Check only one) Hospital: Other -2 No ၉ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 28c. Injury at work? 27. Manner of Death 28a. Date of injury 28b. Time of 28d. Describe how injury occurred Certificate: (Month, Day, Year) injury Natural 5 Pending neral Director: Af 1 Yes 2 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Gertifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and 30 Name a of person who completed cause of death (Item 23a) (Type, Print) 5601 tow 31. Date filed (Month, Day, Year) 62. Registrar's Signature State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND ITEM#22perFH, G924, 2/10/2012, WS State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 1637 PM argaret Edward 01 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Center Ba Itimore University Mary land Medica 9. Birthplace (State or Foreign Country) NY Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs, last birthday) 8. Date of Birth **Funeral** 1 M 2 XF Months Hours Min NY 52 Director 061-54-0605 Usual Residence of Decedent show 10a. State 10b. County the Maryland at 10c. City. Town or Location 10d. Inside City Limits Director notified 28a-f 1 Yes 2X No MD Wicomico Salisbury 10e. Street and Number 10f. Zip Code 9 10g. Citizen of What Country? ms 23a or must be by Funeral U.S.A. 104 Louise Avenue 21804 and Mental Hygiene.
is marked other than "natural", or items is marked other than "natural", or items raumatic event, the Medical Examiner mu Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, 11. Marital Status Armed Forces?
1 ☐ Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: If Yes, Give Year or Dates Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 1 2 College (1-4 or 5+) Postal Postal Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev John Donelon Anna Donegan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Amy Edwards Salisbury, 104 Louise Ave., MD 21804 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) Gate of 2/6/12 Hawthorne, NY Heaven 21. Signature of Fun-22. Name and Address of Facility Carry in Function Harman F.S. 7221 Craybirn Drive Cl 418 U.S. Rte 6, Mahopac, NY en Burnie, MD 10541 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Intracrania Hemorrhag disease or condition resulting in death) days Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine Due to or as a consequence of cause. Enter Underlying After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Dav Year 5 Other (specify) Pregnant at time of death □ Pregnant
 □ Unknown
 □ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 2 🗌 No 1 Yes Be 25. Was case referred to medical the funeral director, 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗆 No မ 1 M Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 26c. Injury at work?
1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 🕅 Natural 5 Pending iniury 2 Accident
3 Suicide Investigation 24 hours after deat Funeral Director; 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after de

To the Funeral Directo

completed filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29c. License number 29d. Date signed (Month, Day, Year) 30 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

FEB 0 9 2012

sarke!

32. Registrar's Signature

S

Greene

51

21201

Baltimore, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

lary Elizabeth E		nuel-Mandak S	State of Maryl	and /		artment of			Menta	al Hy	giene		20	12	0375
Dhysisis		Registrar 1. Decedent's Name (First, Mic	Idle Last)			uncate of	Dealli			2	Re 2. Date of Dea	eg. No. th			3. Time of Death
Physicia Medical Examir		Mary Elizabet		_Mano	łak						Month February 4	Day 4, 201	Year 2		0710 hrs
1		4a. Facility Name (if not institu	ion, give street and n	umber)	<i>a</i> ca. x	T	b. City, To	wn, or L	ocation of				County of	Death	
1		St. Agnes Hospital					Baltime	ore						n,	′a
Funeral		5. Social Security Number	6. Sex	7. Age	(In yrs. I	ast birthday)	If Under Months		If Under Hours	24Hrs. Min.	1		1	BirthForeign	nplace (State or
Director		214-66-5968	1 M 2 X F		58	Yrs		Days	Hours	IVIII.	10/11	/19!	53	Cou	ntry) NC
h	ļ	Usual Residence of Decedent 10a, State 10b, Count		14	Oc. City	Town or Locat	ion							г	10d. Inside City Limits
ow an				ľ		altimor									1 Yes 2 No
Maryland 28a-f sho	핡	MD n/	a		ь	altillor	10f. Zip 0	ode			11	0g. Citiz	en of Wha		
th the Maryland 23a or 28a-f sho notified at once,	Director	4023 Colcheste	or Road A	nt '	182			1229	3			1	JSA		
with th		11. Marital Status	12. Was De				s Deceden	of Hisp	anic Origir		cify Yes or No		14. Race -		an Indian, Black,
eath v	Funeral	1 Never Married 2	Married Armed I	Forces?	X No	If Y	es, specify	Cuban,	Mexican, F	Puerto R	tican, etc.)		White,		Indian
after d	Ş.	3 Widowed 4 X	oivorced If Yes, Give Ye			1	Yes 2	X No	specify:				Specify:	LCai.	Indian
hours	ᄝ	15. Decedent's Education (Sp				16a. Deceden during m	it's Usual O ost of worki					16b. K	ind of Busi	iness/In	dustry
hin 72 hours ie. than "natur edical Exam	Bet	Elementary/Secondary (0-1:	<i>'</i>	(1–4 or 5+	-)	LPN						Ι,	Nursi	na	
5-00.	Completed	12 17. Father's Name (First, Midd	e. Last)			LIPIN		18	3.Mother's	Name (I	First, Middle, I			119	
215-(e filed ral Hyg	Be	Arthur Emanue							Sava	nnah	n Hall				
MD 21215-0036 12 should be filed within 7 th and Mental Hygiene. 27 is marked other than umatic event, the Medica	2	19a. Informant's Name/Relatio	nship (Type, Print)			19b. Mailing	Address	(Street	and Numb	er or Ru	ral Route Nun	mber, Ci	ty or Town	State,	Zip Code)
e, MD 21215-0036 I and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. I tiem 27 is marked other than "matural", or items 23a or 28a-f she reraumatic event, the Medical Examiner must be notified at once		Patricia West:	fall / Sis	ter	1						imore,				1227 Fown, State
Baltimore, MI permit. Pages 1 and 2 s Department of Health a Important: If item 27 injury or other traum	1	20a. Method of Disposition 1 X Burial 2 Cremati	on 3 🏋 Removal	from State	e	Place of Dispos crematory or ot	ner place)		=		Date			•	•
Page Page ment of or oth		4 Ponation 5 Other	Specify:		Em	anuel E					3/2012				
Baltimore, permit. Pages lar Department of Hee Important: If ite		21. Signature of Funeral Servi	certicensee								obard F				•
Physician	-	23a. Part I. Enter the disease,	or complications that	caused th	ne death	Do not enter t	0 / W1 ne mode of	LKel dying, s	OS AV	enue diac or r	e, Balt respiratory arr	est, sho	re,M ck, orhear	ary.	land 21229 Approximate Interval
/Medical		failure. List only one cau	se on each line.												Between Onset and Death
Examiner		Immediate Cause (Final disea or condition resulting in death	Due to (or as	a conseq	uence o	therose	TELUL	ic c	arur	OVAS	Culai	DIS	case		
		Sequentially list conditions,	b											_	
	Ē	if any, leading to immediate cause. Enter Underlying Cause		a conseq	luence c	π): 									
, it	Examine	(Disease or injury that initiated events resulting in death) Las	5	a conseq	luence o	of);			_						
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	dical	X UNPENDED	d	23a	,27,	per me,	g926	4-10)-12	sm					
e be ev									_			230	l. Date of d	alivary	
38760 rtificate b ing physi as the bu	3	IF FEMALE: 23b. Was decedent pregnant in past 12 months?	the 23c. If yes		or preg		tal death	3	Ectopic p	oregnan	су	1200	Month		ay Year
Box 68760 e death certificate I the attending physed for use as the b	sicia	1 Yes 2 No 9 V		nant at ti	me of de	eath 5 Ot	her (Specia	(y)				1080			
D. BC	Physician/M	Part II. Other significant cond	9 UIIN		but not r	esulting in the u	ınderlyina d	ause giv	ven in Part	: I.	23e, Did to	obacco	use contrib	ute to t	he cause of death?
Division of Vital Records, P.O. teal or Attending Physician: The law requires that th rs after death. al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach	2	Tartin Galler eighnioans een	Jan Sona Batang	to double.		oodg a.e		g/			1 Ye	s 2	No 3	Proba	ably 4 🗹 Unknown
ords, w require s been si	Completed									_	24a. Was				opsy findings available
COT law r has b	힏										autop	rmed?	de	ath?	ompletion of cause of
Vital Rec ysician: The his certificate director, page		25. Was case referred to medi	ral	_			26	S.Place o	of Death (0	Check or	1 Yes	2[N	0 1 1	✓ Yes	s 2 No
/ital F sician: us certifi director,	Be	examiner?	Hospital: 1	Inpatien	t 2 🗸	ER/Outpatient		10				Reside	nce 6	Other:	
n of hing Phy	٤	27. Manner of Death		e of Injury		28b. Time of	njury 28	Bc. Injury	at Work?	2	28d. Describe	how inju	гу оссите	d	
Vision of or Attending Ph. Or Actending Ph. Director. After in by the funeral in by the funeral	틽		ending vestigation					1 Ye	es 2 l	No					
ivision or Atten after death Director:	Certification:	3 Suicide 6 Co	ould not be 28e. Pla		ry - At h	ome, farm, stre	et, factory,	office bu	ilding, etc.	2	28f. Location (or Town, \$		nd Numbe	r or Rur	al Route Number, City
Dj sspital hours a neral I		4 Homicide	termined (Specify		10.00					140		()	4		
Divis To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	Medical	(Check only	Physician: To the be xaminer:On the basis	of exam											
To To t	Med	29b. Signature and title of cert	and manner	stated.			29c.	License	number			29d.	Date signe	d (Mon	th, Day, Year)
		110	Mr. Y	. ~	T	1	. 0	O.C.N	1.E.	00	ME	Feb	ruary 5,	2012	
_		30. Name and address of pers													
		Theodore M. King,	1,39,01			Examiner	900 W. I	Baltim	ore Stre	et, Ba	ltimore, M	D 212	23		
St Regist	ate	31. Date filed (Month, Day, Yea	17)	Registrar'	s Signat	ure for M	1								
regisi	411	1 60 1 17 ZI	II (Sept 15)		100	A 100 MILES									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 1703 PM ona orae 2012 Fabruary Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** The Johns Hopkins Hospital Baltmore N/A 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign
Country) 7. Age (In yrs. last birthday) **Funeral** Director 214-89-8503 1**XX**M 2 □ F 25 Ecuador 03/09/1986 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Maryland Director 1 🗆 Yes 2 🔀 No Ecuador Guayas Guayaquil 10f. Zip Code 10e. Street and Numbe 10g. Citizen of What Country? Funeral Urb. La Cumbre MZ6B Villa 1 N/A Ecuador death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. Medical Examiner 0 1 X Never Married 2 ☐ Married Completed by Yes 2 XNo Baltimore, Maryland 21215-0036 1 X Yes 2 □ No Specify: Ecuadorian If Yes, Give Year or Dates Specify: Hispanic 'natural", 3 Divorced Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working and Mental Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the Student +4N/A other traumatic event. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) P Maria Del Carmen Jorge V. Faytong 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ge 1 and 2 s nt of Health : If item 27 Jorge V. Faytong - Father Urb. La Cumbre MZ6B Villa 1 Guayaquil Ecuador 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date emetery, crematory or other place) ☐ Burial 2 【XCremation 3 ☐ Removal from State ò Department of Important: If any injury or once. Atlantic Crematory 02/10/2012 Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
David J. Weber Funeral Homes P.A.
401 S. Chester Street Baltimore, Maryland 21231 Signature of Funeral Service Licens e Part 1. Enter the disease shock, or heart failure. lications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, the cause on each line. Interval Between Immediate Cause (Final Onset and Death Ph, ician se or condition Medical resulting in death) o (or as a consequence of) Examiner Hremi Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury that initiated events attending physician and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed after death. Due to (or as a consequence of) resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) igned by the atter be detached for in the past 12 months? Year Month Dav Pregnant at time of death
Unknown 2 No g Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown been signated beautiful the beautiful the second of the se 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed After this certificate funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မ 1 Yes 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 27. Manner of Death 28b. Time of Certificate: 1 X Natural 5 Pending 1 \square Yes 2 🗌 No Director: A Accident Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined within 24 hours a To the Funeral L To the Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

auven A Mauvo 31. Date filed (Month, Day, Year)
FFR 1 0 2012

FEB 1

Baltimore, MD 21287

e and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registr

February 8

2012

		Plea	se Type or Pri				_		gible.	
		For State	State of Ma	,	partment of F		1ental Hy	giene		on on my on t
	_	Registrar 1. Decedent's Name (First, Middle,	l ast)	C	ertificate of L	Jeath	2. Date of De	Reg. No. 2	012	03/61
Physicia		John	•				Month Feb.		0 1 2	3. Time of Death
Medic Examin		4a. Facility Name (if not institution,	give street and number) worth Aven	116		r Location of Death		4c. Count	y of Death	1
Funeral		5. Social Security Number	6. Sex 7. Age	e (In yrs. last birthda	y) If Under 1 Year	If Under 24 Hrs.	8. Date of Bir	rth	9. Birthp	place (State or Foreign
Director		218-64-4383 Usual Residence of Decedent	1 X M 2 □ F	56 Yrs	Months Days	Hours Min.	May2	0 (°°°1)955	Coun	MD
yland -f show ed at	ctor	10a. State 10b. County MD Balt	imore	10c. City, Town or Middl	Location e River				1	0d. Inside City Limits
he Mar or 28a e notifi	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Coun	1 Yes 2 XNo
h with t ns 23a nust bo	Funeral	1532 Chilw	orth Avenu			220		USA		
er deati or iten niner r	by Fu	11. Marital Status1 ☐ Never Married 2 ☐ Marri	12. Was Decedent E Armed Forces? ed 1 \sum Yes 2 \sum X	Ever in U.S. 1	Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (Spe an, Mexican, Puerto	cify Yes or No- Rican, etc.)	14. Ra	ce - Americ ack, White, e	
urs afte ural", al Exar		3 🛚 Widowed 4 🗆 Divorced	If Yes, Give Year or Dates.		1 Yes 2 X No	Specify:		Specif	y: Wh	nite
72 ho an "nat Medica	Completed	15. Deceden (Specify only highes	t grade completed)	(Gi	cedent's Usual Occup ive kind of work done o b. DO NOT use retired)		ng	16b. Kind of I	Business Ind	dustry
within /giene. ner th e t, the I		Elementary/Seconday (0-12) 12th	College (1-4 or 5		Steel Wo				ion	
be filed lental Hy rked oth	To Be	17. Father's Name <i>(First, Middle, La</i> Frank Gast	,			18. Mother's Name Mar	e (First, Middle, Y Gli	, Maiden Surnan nski	ne)	
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationsh DennisF. St		19b. M.	ailing Address (Street a	and Number or Rura Baltimor	Route Numbere Str	er, City or Town, eet Ba	State, Zip C	Code) MD 21224
1 and of Heal fitem		20a. Method of Disposition	·	20b. Place of Dis	sposition (Name of		Date	20c. Location	- City or To	wn, State
: Page tment tant: It jury or		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S _i	pecify)	Sacred	Heartofje	esus 2/1	0/12	Balt	imore	= MD
permit Depar Impor any in		21. Signature of Funeral Service Li	densee	162	22. Name and Addres	. 50		e Ave.		
	=	23a. Part 1. Enter the disease, or one shock, or heart failure. List or	comply ations that caused	death. Do not	enter the mode of dying	ly Funer g, such as cardiac o	r respiratory a	rrest,	ESSE2	Approximate. Interval Between
Physician/		Immediate Cause (Final disease or condition	Cocor	acu Ac	tery Di	sease				Onset and Death
Medical Examiner		resulting in death)	Due to (or as a	a conse ence of):	o					10 40000
	iner	Sequentially list conditions, if any leading to in models cause. Enter Underlying	b. Due to of as a	a consequence of):	M. Cur	- 1				10 georg
executed an and rial-transit	Examiner	Cause (Disease or linjury that initiated events resulting in death) Last	c. Due to (or as a	betes a consequence of):	Thellitus	type	<u> </u>			10 years
	edical	,	d							
eath certifica attending pl)/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnancy				224 D	ata of delive	
or Attending Physician: The law requires that the death certificate be after death. Director: After this certificate has been signed by the attending physici in by the funeral director, page 2 should be detached for use as the bu	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No		2 Fetal death	3 Ectopic pregnanc 5 Other (specify)	; ;			ate of delive onth	Day Year
ires that the dea signed by the a Id be detached f	/ Phy	9 ☐ Unknown Part II. Other significant condition		ut not resulting in th	ne underlying cause giv	ven in Part I.	23e. Did t	tobacco use cor	tribute to th	e cause of death?
luires then signer and be	ed by	- Congesti	ve heart	failu	re		1,20	Yes 2 □ No	3 🗆 Prob	oably 4 🗆 Unknown
law require has been si je 2 should b	Completed	Chronic	ve heart obstruc	tive p	ulmonar.	y diseas	24a. Was	psy	prior to cor	osy findings available impletion of cause of
s ic ia n: The la certificate ha irector, page 2		hyper † 25. Was case referred to medical	ension		00.00	f Dth (Cht		ormed? 2 No	death? 1 Yes	2 🗆 No
lysician: is certific director,	To Be	examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatie	ent 2 🗆 ER/Outpa	Oth	ace of Death (Check er: 4 Nursing Ho		idence 6 🗆 Otl	ner (Specify))
iding Phys th. After this funeral dir	ate:	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of injui (Month, Day	ry 28b. Time (, Year) injur	y work	y at		how injury occur		
Attendir r death. sctor: Af by the fu	Certificate:	2 Accident Investig 3 Suicide 6 Could n 4 Homicide determine	ot be 28e. Place of Inju		M 1 L	Yes 2 □ No	28f. Location (Street and Numi	per or Rural	Route Number,
ital or after al Dire		4 - Homicide determin	building, etc	:. (Specify)			City or Tov	wn, State)		
To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completed filled in by the fu	Medical	(Check 2 Medical Ex	Physician: To the best of caminer: On the basis of ex Nurse Practioner: To the	kamination and/or inv	vestigation, in my opinio	on, death occurred at	the time, date a	and place, and de	ue to the cau	use(s) and manner stated
To the within To the comp	2	29b. Signature and title of certifier	Naise Fractioner: 10 the	Desir of my knowledg	29c. License	e number		29d. Date signe	ed (Month, L	Day, Year)
(20)			X		Doc	05713	7	2/8	1201	2
5 M.		30. Name and address of person w		0 1	e, Print)	Onice C	ouite la	05, 1 hi	ting ha	z m,MDazz
Stat		31. FEBd Mo(1/2012ar)	32. Registra	r's Signature	0		-11 J W	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	3	-1
Registra	17		error in the section	A						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ GA KOWSKI February 201^{Year} RIGNIEN 7:15 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Bethesda Montgomery Suburban Hospital If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Hours **Director** 1 X M 2 □ F 54 July 20, 1957 Poland Usual Residence of Decedent show er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Maryland | Montgomery 1 X Yes 2 No Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4903 Edgemoor Lane 20814 Poland filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married by 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) Embassy of Poland 5+ Diplomat other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, permit. Page 1 and 2 should be.
Department of Health and Mental Important: I item 27 is merany injury or other. Lidia Wolf Czeslaw Gajewski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ul. Drewnicka 8 05-220 Zielonka, Poland Lidia Gajewska (Wife) 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place) Metropolitan Crematory 2/10/2012 Alexandria, VA Donation 5 Other (Specify Signature of 22 Name and Address of Facility Metropolitan Funeral Service 5517 Vine St., Alexandria, VA 22310 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate terval Between nset and Death Immediate Cause (Final PANCLESTIC CANCEL Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year 1 U Yes 2 No 9 Unknown Pregnant at time of death Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 XYes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has be 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 No မ 1-2 Inpatient 2 - ER/Outpatient 3 - DOA 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 Pending injury 1 Yes 2 No Accident Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Ecertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one Signature 29d. Date signed (Month. Day, Year) 30. Name and address of person who completed cause of death (Item, 23a) (Type, Print) 64 2. Registrar's Signature

DHMH 17 Rev 06-2011

Registrar

151 FS

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 03762 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Napolean Green Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Joseph Ritchey Hospice N/A Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 220-94-7756 **Director** 1 XM 2 🗆 F 48 07/23/1962 Maryland 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 □ No Baltimore MD N/A ō 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country's item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be i Funeral 868 W. Eutaw St. U.S.A. 212**01** 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. Maryland 21215-0036 1 ☐ Yes 2 No Specify 3 Widowed 4 Divorced Black 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Home Improvement 10th Grade Self Employed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Leroy Green Rosalie L. Hearn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Annette Craddock(sister) 3628 Kenyon Ave., Baltimore, MD 21213 Baltimore. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Surial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Carmel Cem. 02/06/12 Baltimore, MD 21. Signature of Funeral Service Licenses 30 Joseph Brown Jr. Funeral Home PA 2140 N. Fulton Ave., Baltimore, MD21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Ph_sician disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions Examine cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence on): -tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 as IF FEMALE nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ ate has been signed by the atte page 2 should be detached for in the past 12 months? Month Year Pregnant at time of death Dav 2 No Unknown 9 Unknown Records, P.O. ed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Hospital or Attending Physician: The Yes 2 No 1 🗌 Yes 2 No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 1 Yes 2 No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) NA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending injury after death the Accident Investigation 2' Acciden 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number 4 Homicide determined 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2. Medical Examiner: On the basis of examination and/or investigation in my relation due to the cause(s) and manner as stated Medical 29a. Certifier . Vietely (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 29b. Signature and title of certifie 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) W18-134 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 7:03 PM rebruc / Henderson Carrie Jane Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Meritus Hospital Hagerstown Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours Min Jan 9, 1950 Virginia 224-72-1098 Director 1 □ M 2 🗓 F 62 Usual Residence of Decedent 28a-f show 10a. State 10c. City. Town or Location 10d. Inside City Limits notified at Director 1 Yes 2 X No Keedysville MD Washington 10e. Street and Numbe 10f. Zip Code ō 10g. Citizen of What Country? er than "natural", or items 23a or the Medical Examiner must be Funeral 21756 USA 5216 Porterstown Road death 1 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 72 hours after 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working th and Mental Hygiene.
7 is marked other than traumatic event, the Me life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Manager Restaurant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Ernest Clinton Mills Eva Finch permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5216 Porterstown Road Keedysville, MD 21756 Robert Lee Henderson/husband 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place) Final Journey Crematory 02/11/12 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) Coing Home Cremation Service Beverly L. Heckrotte, P.A. C. P.O. Box 784 Clarksville, MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Autoimmune Hemolytic Ph. i ian Y-Car Severe disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or injury that initiated events resulting in death) Last Metabolic burial-trar attending physician Physician/Medical or Attending Physician: The law requires that the death certificate be Box 68760 the use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No for Month Day Year Pregnant at time of death the & P.O. been signed by t should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 \sum Yes 2 \sum No 24a. Was an cate has l perform certificate 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 2 No ျှ 1X Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred hin 24 hours after death.

the Funeral Director: After in pletely filled in by the funer 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F 29b. Signature and title of certifier D68995 2012

Registrar

DHMH 17 Rev 06-2011

State

Hagerstown, NOD 21740

Name and address of person who completed cause of death (Item 23a) (Typ

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ February 20**°**2 8:30 Рм Rosa Lee Harris Medical 4a, Facility Name (if not institution, give street and number) 4h City Town or Location of Death 4c. County of Death Examiner Baltimore Glen Meadows Glen Arm 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 X F Hours Min. March 29 Vírginia 89 ₫922 220-12-5191 Director Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Baltimore Glen Arm Maryland 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral with 21057 U.S.A. 11630 Glen Arm Road death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12 Was Decedent Ever in U.S. 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2X Married Yes 2 X No within 72 hours after Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 K No Specify: Specify: White 3 Divorced Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 72 al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) the Homemaker Own Home other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ith and Mental H ၉ Thomas Grooms Fannie Mae Mundy permit. Page 1 and 2 should be Department of Health and Mer Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1442 Sharon Acres Road Forest Hill, Md. Debbie Harris / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 K Cremation 3 Removal from State 2/10/2012 HilltopServiceCorp. Towson, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funer 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 york Road towson, maryland 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between shock, or heart failure. List only one cause on well Immediate Cause (Final Onset and Death Physician/ 121 disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, cause (Disease or iinjury Due to for as a consequence off. that initiated events Due to (or as a consequence of) resulting in death) Last the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as the IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death nse 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? for Month Day Year Pregnant at time of death I signed by the a Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an or Attending Physician: The law certificate has page 2 s autopsy death? 2 No Cereby 1 🗌 Yes ☐ Yes 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Hospita Other: 1 Yes 2 100 မ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: iniury work? 1 ☐ Yes Natural 5 Pending 2 🗆 No 2 Accident
3 Suicide
4 Homicide Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check ertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signa ure and title of ce 29d. Date signed (Month, Day, Year) Ro7954 CARP 2012 eted cause of death (Item 23a) (Type, Print) 10 and address of pe

DHMH 17 Rev 7/2009

State Registrar E ET

Surri

Towson

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ February 2012 Wiley Henley Hall 5:30a Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 462 Bonnett Street Aberdeen Harford 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Days Hours 1XXM 2 | F **Director** 227-42-9356 Sept. 10, 1933 Virginia 78 Yrs Usual Residence of Deceder show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location notified at Director or 28a-f 1 X Yes 2 No Maryland Harford Aberdeen 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be n Funeral 462 Bonnett Street 21001 USA items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian Examiner Black, White, etc. or. þ 1 Never Married 2 Married 1XXYes 2 No 1954. Baltimore, Maryland 21215-0036 an "natural", c Medical Exam If Yes, Give Year or Dates. 1 Yes 2 No Specify: Specify: white 3

Widowed 4 ☐ Divorced 1955 Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) traumatic event, the shipping foreman manufacturing Be 17. Father's Name (First, Middle, Last) 18, Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be file of Health and Mental fitem 27 is marked of marked ည Cora Blevins Hobart Hall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1853 Wye Mills Lane, Bel Air, MD 21015 Judy Herman (daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Page 1 Department of Important: If it any injury or o once. 1 X Burial 2 Cremation 3 Removal from State 4 Donation Harford Memorial Grdns. 2/6/12 Other (Specify) Aberdeen, Maryland 22. Name and Address of Facility ss of Facility Tarring—Cargo Funeral Home, P.A. Maryland 21001 21. Signature Aberdeen, 23a. Part 1. Enter the diseas of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line nterval Between Onset and Death Immediate Cause (Final 0 Providen/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): the at ending physician and ched to use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death detached for use 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Year Pregnant at time of death Linknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown To Be Completed 24b. Were autopsy findings available prior to completion of cause of 24a, Was an has autopsy page 2 perform death? 1 Yes 2 No 2 N Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27, Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred Director: After 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No M 2 Accident Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide determined City or Town, State) within 24 hours a

To the Funeral C

completely filled Hospital Medical 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the sine, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

To the

2/12

State Registrar

DHMH 17 Rev 06-2011

29b. Signature and title?

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

20c. License number

Will I

29d Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 6 per fh g924 2-23-12 vt. State of Maryland 7 Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 02 Physician/ Joseph Huerta Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Stella Maris Hospice Timonium 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Min 472-22-1317 **Director** 1 K M 2 K 86 11/25/1925 Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location notified at Director Aberdeen Marylan¢ Harford ms 23a or r must be n 10e. Street and Number 10f. Zip Code 21001 Funeral 399 Clover Street 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. the Medical Examiner 8:05 а.ш. 0 Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1X Yes 2 No Specify: "natural", 3 ☒ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working I Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Aeronautical Engineer 12 Department of Health and Mental Hygier Important: If item 27 is marked other any injury or other traumatic event, the once. Be 2012 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Conceptaion Alvarez Matias Huerta

19a. Informant's Name/Relationship (Type, Print)

Joseph M. Huerta /

1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20a. Method of Disposition

Physician Medical Examiner

FEBRUARY

attending physician

Records, P.O. Box 68760

Division of Vital

JOSEPH HUERTA

burial-transi use as To the Hospital or Attending Physician: The law requires within 24 hours after death.

To the Funeral Director: After this certificate has been sign completely filled in by the funeral director, page 2 should by

Me

29b. Signature and

30. Name and address

JACKIE JONES,

_	shock, or heart failure. List only o Immediate Cause (Final		333 S. Parke S	Funeral Home, P. L, Aberdeen, MD correspiratory arrest,	Approximate Interval Between Onset and Death
	disease or condition resulting in death)	a. PROSTATE CANCER Due to (or as a consequence of):			
Examiner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury	b. Due to (or as a consequence of):			
dical Exa	that initiated events resulting in death) Last	c. Due to (or as a consequence of):			
Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	23d. Date of c Month	lelivery Day Year
ed by Pr	Part II. Other significant conditions of	ontributing to death but not resulting in th	ne underlying cause given in Part I.	23e. Did tobacco use contribute 1 Yes 2 No 3	
Complet				autopsy prior to performed? death?	autopsy findings available o completion of cause of les 2 \(\sum \text{No}\)
Be	25. Was case referred to medical examiner?	Hospital:	26. Place of Death (Ch	eck only one)	
2	1 Yes 2 X No 27. Manner of Death	1 Inpatient 2 ER/Outpa		Home 5 ☐ Residence 6 X Other (Spe	ecify) HOSPICE
Certificate:	1 X Natural 5 Pending 2 Accident Investigation			28d. Describe how injury occurred	
	3 Suicide 6 Could not b 4 Homicide determined		street, factory, office	28f. Location (Street and Number or F City or Town, State)	Rural Route Number,
Medical	(Check 2 Medical Exam	sician: To the best of my knowledge, dea iner: On the basis of examination and/or in se Practitioner: To the best of my knowled	vestigation, in my opinion, death occurred	d at the time, date and place, and due to the	e cause(s) and manner stated

29c. License number

TIMONIUM, MD 21093

20b. Place of Disposition (Name of cemetery, crematory or other place)

201^{ear}

4c. County of Death

Baltimore

10g. Citizen of What Country?

16b. Kind of Business/Industry

Civil Service

20c. Location - City or Town, State

29d. Date/signe/i (Month, Day, Year) 2012

MN

Race - American Indian, Black, White, etc.

Specify: Hispanic

8:05

Birthplace (State or Foreign Country)

10d. Inside City Limits

1 Xyes 2 No

08

ŬSA

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14054-B Vista Dr, Laurel, MD 20707

Harford Mem.Gardens 2/13/2012 Aberdeen

Date

DHMH 17 Rev 06-2011

State Registrar

10 /

2300 DULANEY VALLEY RD.

of person who completed cause of death (Item 23a) (Type, Print)

CRNP

Registrar

DHMH 17 Rev 06-2011

State

30. Name and address of person

SI

npleted cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death February 2, 2012 8:05 P M Physician/ Marjorie Irene Joseph Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Howard Columbia Gilchrist Center If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🔀 F Days sept 29 1939 Washington, DC 578-48-8644 Director 72 Usual Residence of Decedent works 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits aţ within 72 hours after death with the Maryland Director "natural", or items 23a or 28a-f s edical Examiner must be notified 1 Yes 2 No Ellicott City Maryland Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21042 3542 Rosemary Lane Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 2 **X**No þ 1 Yes : Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced Completed Year or Dates ed other than "natu 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene Important: If item 27 is marked other tha any injury or other traumatic event, the A once. Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18, Mother's Name (First, Middle, Maiden Surname) (unk) 2 Freda Mae Ralph Boose 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3542 Rosemary Lane Ellicott City, MD 21042 Annjalenna Kirchhoff/daughter Baltimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cometer, crematory or other place)
Final Journey Crematory 02/06/12 1 Burial 2 X Cremation 3 Removal from State Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Goiling Homes Cremation Service Beverly L. Heckrotte, P.A. Clarksville, MD 21029 MO1251 23a. Part 1. Enter the blease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ IMMI disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, Due to or as a consequence of cause. Enter Underlying Cause (Disease or iinjury that initiated events Exami or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death by the a 9 Unknown 9 Unknown s been signed by t 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 🗌 Yes 2 No 3 □ Probably 4 □ Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an has bade (this certificate Yes 2 No Yes Division of Vital 25. Was case referred to medica funeral director, 26. Place of Death (Check only one) Be examiner? 2 X NC Hospital Other: 1 🗌 Yes ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: within 24 hours after death.

To the Funeral Director: After of the funeral picture in the funeral completed filled in by the funeral completed filled in by the funeral filled in the funeral filled 5 Pendina injury M Investigation 2 Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined building, etc. (Specify) Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature a nd title of certifier License number name and address of person who completed cause of death (Item 23a) (Type, Print) State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Ali Jawdat 2012 Nameer 8:45 A M February Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** County of Death Montgomery Bethesda Eden Home Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours 1 **X** M 2 □ F NOV 1 Day, Year 26 Iraq (Director 219-96-1650 86 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits Director ms 23a or 28a-f s must be notified Bethesda 1 Yes 2X No Montgomery MD 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral **USA** 20816 5301 Westbard Circle #145 ral", or items ? 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2X Married Completed by Baltimore, Maryland 21215-0036 1 Yes 2X No Specify "natural", Specify: White 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) ed other than " Elementary/Seconday (0-12) College (1-4 or 5+) of Health and Mental Hygiene. Item 27 is marked other that other traumatic event, the N Freelance Writing Writer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Nazik Tahsin Ali Jawdat 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5301 Westbard Circle #145 Bethesda, MD 20816 Jean Jawdat/wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 a
Department of I
Important: If ite
any injury or ot 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crematory 02/11/12 Woodbine, MD 21. Signature of Funeral Service Licer Going Home Cremation Service P.O. Box 784 MD 21029 Beverly L. Heckrotte, P.A. Clarksville, MO1251 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ Pneumonia disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Dysphagia Sequentially list conditions Examine if any, leading to immediate Due to (or as a consequence of): Cause (Disease or iinjury Late Effect Cerebral Vascular Accidents Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Hypertension Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 Yes 2 No fo Month Day Year Pregnant at time of death 4 Pregnant
9 Unknown 1 ☐ Yes 2 ☐ Unknown detached Division of Vital Records, P.O. is been signed by ti 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy Yes 2 X No 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 X Other (Sp. Assisted Hospital 1 Tes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred XNatural injury work?
1 Yes 2 No 5 Pending Accident Investigation 24 hours after deat Funeral Director: 6 Could not be 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) pleted filled in by determined Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one

To the Ho within 24 To the Fu

Susan J. Miller, M.D. 8218 Wisconsin Ave. #305 Bethesda, MD 20814

31. Date filed (Month, Day Year)

32. Registra's Signature

34. Part J. January

35. Registra's Signature

36. January

37. Registra's Signature

38. Registra's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title

State Registrar 29c. License number

29d. Date signed (Month, Day, Year)

2017

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Charles, Dwane, Ketcham 02 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Neurans Affairs Medical Curtin Baltimore - Baltimori 9. Birthplace (State or Foreign Date of Birth **Funeral** Months Hours Min (Month, Day, Year) 1951 New York 60 212-52-3277 Director 1 2 M 2 D F 28a-f shov 10d. Inside City Limits at 10a. State 10c. City, Town or Location Director event, the Medical Examiner must be notified MD 1 Yes 2 No Anne Arundel Curtis Bay 10f. Zip Code 0 10e. Street and Number 10g. Citizen of What Country? 23a Funeral 4600 Curtis Avenue 21226 United States tems death 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc o, þ 1 Never Married 2 Married 1≥ Yes If Yes, Give Baltimore, Maryland 21215-0036 hours after 1 Yes 2 No Specify Specify. "natural", White 3 Widowed 4 Divorced Completed Year or Dates. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4 or 5+) 2 should be filed with the and Mental Hygien 7 is marked other the Heavy Equipment Operator Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Matthew Llewelyn Ketcham Etta Pearl Edenfield other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ge 1 and 2 short of Health a Christina Pinder /Daughter 166 Rivendale Drive Columbia, SC 29229 Feb 08 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of IImportant: If ite
any injury or ot cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 2012 Beltsville, Maryland 4 Donation 5 Other (Specify) Chesapeake Crematory 21. Signature of Funeral Service Licensee 22. Name and the confaind Funeral Alternatives 8717 Green Pastures Drive Towson Maryland 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examin Cause (Disease or injury attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) ed by the a detached t Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, To the Hospital or Attending Physician: The law requires 1 ☐ Yes 2 ☐ No 3 X Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? page 2 certificate 1 XYes 2 □ No 1 ☐ Yes 2 🗹 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 **X** No မ ▼Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, After this filled in by the funeral 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending X Natural Certifical Accident Suicide Investigation 24 hours after deat Funeral Director: 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier 😰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie PZ14971

State Registrar Baltimure, MD 2120

22 Sayin Greene St

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryla				Mental Hyg	iene	20771
		·	1 - State Registrar	Ce	rtificate of	Death		eg. No2 U 2	03//1
5,	Physicia	an	1. Decedent's Name (First, Middle, Last)				2. Date of Dea Month	Day Year	3. Time of Death
	/Medic		Rose M. Kunze 4a. Fecility Name (If not institution, give street and number)		4b. City, Town, or	Location of Deat	Kebruar	4c. County of Dea	
	Examin	eı	Lorien Bel AIR		Bel	AIR		Hai	ford
	Funeral		10 H	s. last birthday	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	(Month, Day	, Year)	rthplace (State or Foreign ountry)
75,	Director		215-32-5315	75 Yrs.			May 10,	1936 M	aryland
	yłand how			City, Town or L	ocation				10d. Inside City Limits
	88-f s	Director	Md. Balto.	White					1 ☐ Yes 2X No
	with the	Dire	10e. Street and Number 5808 Gambrill Road		10f. Zip Code 2116	2	1	I0g. Citizen of What C USA	ountry?
	death me 23	Funerai	11 Marital Status 12. Was Decedent Ever in	U.S. 13.	Was Decedent of H		Specify Yes or No-	14. Race - Am	
9	be filed within 72 hours after death with the Maryland ald Hygiene. Ad other than "naturel", or leme 23a or 28a-f show other than "naturel", or leme 23a or 28a-f show event, the Madical Examiner must be notilised at		1 Never Married 2 Married Armed Forces? 1 Never Married 2 Married If Yes, Give		If Yes, specify Cuba 1☐ Yes 2XNo		to Hican, etc.)	Black, Wh	white
Maryland 21215-0036	hours turel',	ed by	3 Widowed 4 Divorced Year or Dates: 15. Decedent's Education	163 Dog	edent's Usual Occup			16b. Kind of Business	
Ċ	in 72 n "na Wedic	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give	e kind of work done of DO NOT use retired	during most of wor ()	rking	FOO. KING OF DUSINESS	unidustry
77	filed with Hygiene Ather the	Com	12 th	В	ookkeeper		9	CPA	
n n	be be	Be	17. Father's Name (First, Middle, Last)				me (First, Middle,	Maiden Sumame)	
2	should by nd Menta marked umatic e	မ	Kemp Sheppard 19a. Informant's Name/Relationship (Type, Print)	19h Maii	ing Address (Street	Lettie		r, City or Town, State,	Zin Code)
	s 1 and 2 should f Health and Mer ttem 27 is marke other treumatic		William Kunze, Sr.		8 Gambril			rsh. Md. 2	a *
Se,	of Head		20a. Method of Disposition 20b.	Place of Disp	osition (Name of omatory or other place	-2-4		20c. Location - City o	
Ĕ	Pages ment of ant: If it		1 № Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	olly Hi			-2012	Middle Riv	er, Md.
Baltimore,	permit. Pages Department of I Important: If Its any injury or o		21. Signatur of Funeral Service Acordsee	[]	2. Name and Addre	50		Funeral Ho	
	** * 1	-	23a. Part1. Enter the disease, or complications that caused the de					ham, Md.21 est,	Approximate
į.	Physician		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition END STACE	e λε	mentia				Interval Between Onset and Death
7	/Medical		resulting in death) Due to (or as a conse		PICNIII				
	Examiner	_	Sequentially list conditions, if any, leading to immediate	oguanaa af):					
ī	nted Insit	Examiner	cause. Enter Underlying Cause (Disease or injury	iquence oi):					
S)	be executed cian and burial-transit		that initiated events c	equence of):				-0-1-0-1	
8/60	o ys	licai	d						
X 68	sertific ding p	/Mec	IF FEMALE: 23c. If yes, outcome of preg	nancy					
gox	The law requires that the death certifica tie has been signed by the attending ph bage 2 should be detached for use as th	by Physician/Med	23b. Was decedent pregnant in the past 12 months? 1	tal death 3	☐Ectopic pregnancy ☐ Other (specify)			23d. Date of de Month	Day Year
r Ö	that the de ned by the a detached f	hys	9 Unknown						
10	w requires that been signed to should be det	by P	Part II. Other significant conditions contributing to death but not re	9	, ,			bacco use contribute	
0	requi	eted	CORONARY ARTERY DISEASE	1 1441	ERTENST	oN,	1 🗆 Y		Probably 4 Unknown
Hecords	The law ate has page 2 s	ompieted	ATRIAL FIBRILLATION				24a. Was a autop: perfor	sy prior to death?	autopsy findings available completion of cause of
Vital		C	25. Was case referred to medical			26 Place of De	1 ☐ Yes ath (Check only or	2 No 1 Ye	s 28No
Ξ	Physicien: this certific ral director,	ToB	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2	☐ ER/Outpatie	int 3□ DOA Cth			ence 6 Other (Sp	ecify)
n O	ing Pt		27. Manner of Death 1 MarNatural 5 Pending 28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Wor	K?	28d. Describe h	ow injury occurred	
DIVISION	death death stor: / the fi	cat	2 Accident investigation 3 Suicide 6 Could not be determined determined	home farm c		Yes 2 □No	28f Location (S	treet and Number or F	Qural Poute Number
<u>≥</u>	el or A s after 1 Direct	Certification:	4 Homicide determined building, etc. (Spec	ify)	incor, raciory, office		City or Tow	n, State)	rosto rumbor,
	ne Hospitel or Attending Phys in 24 hours after death. he Funerel Director: After this optetely filled in by the funeral director	edical	29a. Certifier (Check only (C	nowledge, dea	th occurred at the tir	ne, date and place	e, and due to the curred at the time.	ause(s) and manner a	as stated.
	To the Hospitel or within 24 hours after To the Funerel Dir completely filled in	Medi	one) and manner stated.		no- Line			10.4 5-1-1-1-1-1-1-1-1-1	The David Variable
	- 3 - 8 - 8 - 8 - 8 - 8 - 8 - 8 - 8 - 8		Madhatina MX		NU	-744		OZIOTI	2012
	7 My		30. Name and address of person who completed cause of death (It	əm 23a) (Type	, Print)	J (= (0 010 11	~01~
			SURESH DHANTANI MD. 6	225,0	INION AL	E, HAY	RE DE	PACE, M	1021078
	Sta Registr	202	31. Date filed (Month, Day, Year) 32. Registrar's Sig	nature	a Vel			,	

		1	For State Registrar	State of Mai	yland			e of D		ila ivi		Reg. No	711	2	03772
	Physicia		1. Decedent's Name (First, Middle, Last)	KUSA	CA					2. Date of Dea		7 201 ^{Y2ar}		3. Time of Death 3:13 A M
	Medic Examin	al .	CHRISTAVINA 4a. Facility Name (if not institution, give	treet and number)	KUSA	IGA	-		ocation of		BBROIN	40	. County of De		
1			3237 75th AVENUE	#201	In the least	hirthday	HY If Unde		If Under 2	4 Hrs.	8. Date of Birt		RINCE C		Ce (State or Foreign
	Funeral Director		5//-39-4515	M 2 🖾 F 7. Age (ln yrs. last 8	Yrs.	Months	Days	Hours	Min.	(Month, Da	r Ž ^{ear} l	983 TA	NZI	NIA
	and show d at	for	Usual Residence of Decedent 10a. State 10b. County		l0c. City,	Town or Loc	ation							100	I. Inside City Limits
	Mary 28a-f	irec	MD PRINCE G	EORGE'S	НУ	ATTSV						10- 0	itizen of What (Caunto	1 X Yes 2 No
	with the s 23a or ust be r	Funeral Director	10e. Street and Number 3237 75TH AVENUE	# 201			10f. Zip	0785				USA		20umi	,:
920	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ed by Fun	11. Marital Status 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Even Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates.	er in U.S. o			dent of His cify Cubar 2 📉 No		in? (Spec Puerto R	ify Yes or No- ican, etc.)		14. Race - An Black, Wh Specify: BI		
Maryland 21215-0036	thin 72 hour ene. than "natu he Medical	Completed by	15. Decedent's Ec (Specify only highest gra Elementary/Seconday (0-12)			16a. Deced (Give I life. De		rk done di e retired)	tion uring most o	of workin	g		(ind of Busines		stry
and 2	ntal Hygie ed other event, ti	To Be (17. Father's Name (First, Middle, Last) WILLY KUSAGA						18. Mother		(First, Middle,	Maiden AMAT			
aryl	nould but the same of the same		19a. Informant's Name/Relationship (T)	pe, Print)		19b. Mailir	ng Addres	s (Street a	nd Number	r or Rural	Route Numbe	er, City o	r Town, State,	Zip Co	de)
Ž,	nd 2 sh ealth a m 27 is ner trai		LAVORN_CRYOR/HUSE	AND					NUE #				E, MARY		
Baltimore,	Page 1 a ment of H ant: If ite ury or ott		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specif.	Removal from State	cer	ce of Dispo netery, cren E OF	natory or HEAVI	other place EN CE	ME.:	2/20	/2012	SII		RIN	G,MARYLAND
Balt	permit. Departi Import any inj	22. Name and Address of Facility J. B. JENKINS FUNE 7474 LANDOVER ROAD HYATTSVILLE, MA									LE, MAR	YLA	ND 20785		
	23a. Part 1. Enter the dispase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, dr.heart fallure. List only one cause on each line. Immediate Cause (Final disease or condition METASTATIC COLON CANCER										1	Approximate nterval Between Onset and Death			
C	Medical Examiner	2 10	disease or condition resulting in death)	a. METAST Due to (or as a			N CAI	NCEK						T	
		niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a	conseque	nce of):									
	rate be executed physician and the burial-transit	edical Examiner	Cause (Disease or iinjury that initiated events resulting in death) Last	c. Due to (or as a	conseque	nce of):									
760	icate b physics the b			d											
Box 68	law requires that the death certificate be executed has been signed by the attending physician and e 2 should be detached for use as the burial-transif	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2▼ No 9 ☐ Unknown	23c. If yes, outcome o 1 Live Birth 2 4 Pregnant at 9 Unknown	☐ Fetal	death 3 L	☐ Ectopic ☐ Other (s	pregnanc	у			9	23d. Date of Month		y Day Year
s, P.O.	ires that the dea signed by the a Id be detached f	2	Part II. Other significant conditions of	ontributing to death bu	t not resul	Iting in the I	underlying	cause giv	en in Part I	l.	1				cause of death?
Division of Vital Records,	e law require has been si ge 2 should	Completed						· ·		_	_ perf	opsy ormed?	prior death	to com	sy findings available pletion of cause of
Ä	Physician: The law this certificate has ral director, page 2:	Be Co	25. Was case referred to medical				-	26. Pl	ace of Deat	th (Check	1 \(\simeg\) Yes	2 L X	No 1 L	Yes 2	? ☐ No
Vit	nysicit	10 B	examiner? 1 Yes 2 No	Hospital: 1 Inpatie	nt 2 🗆 E	R/Outpatie	nt 3 🗆 I	Othe	er: _4 🗌 Nu	rsing Ho	me 5X Res	idence	6 Other (Sp	ecify)_	
n of	ding Pt h. After th funeral		27. Manner of Death 1 Natural 5 Pending	28a. Date of injury (Month, Day,		28b. Time o injury	f M	28c. Injury work	yat ? Yes 2 □	- 1	28d. Describe	how inju	iry occurred		
ivisio	l or Atten after deat Director:	Certificate:	2 Accident Investigatio 3 Suicide 6 Could not b 4 Homicide determined		ry - At hon (Specify)	ne, farm, st					28f. Location City or To		and Number or fe)	Rural I	Route Number,
	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director. After this completed filled in by the funeral di	Medical	(Observe of Madical Evans	sician: To the best of r iner: On the basis of ex se Practioner: To the b	amination	and/or inves	stigation i	n my opinio	on death oc	ccurred at	the time, date	and blac	ce, and due to t	ne cau:	se(s) and manner stated.
	To th withir To th	2	29b. Signature and title of certifier Jocelyne. A			•	25	c. License				29d. E	ate signed (Mo	nth, D	ay, Year)
			30. Name and address of person who	completed cause of de	eath (Item :	23a) (Type,	Print)		•				BRUARY		
P			JOCELYNE KOUATCH	OU MD 4041	POW	DER M	ILL I	ROAD	# 600	CAL	VERTON	,MAF	RYLAND	207	05
	Sta	ite	31. Date filed (Attended Pay Your) 201		r's Sign Itu	ire La	Kal								

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2 16 600 nn 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death llstone If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign Months GEORGIA **Director** 28a-f show 10a. State 10c. City, Town or Location traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director BALTIMORE 1 Tes 2 No OWINGS Mill 10e. Street and Number ò 10g. Citizen of What Country? Funeral CORNbuR items 23a U.S.A. be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 2. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married and Mental Hygiene. is marked other than "natural", or ģ 1 ☐ Yes 2 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: BLACK Completed 3 Divorced 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) JANIFORIAL Be 17. Father's Name (First, Middle, Last) (uNK NOいれ) 18. Mother's Name (First, Middle, Maiden Surname, မ permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 🗦 /// 7 Court, OWNESMills JANNET M. 33 CORNBURY 20a. Method of Disposition 20b. Place of Disposition (Name of Date 1 Durial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5/2012 BALTIMORE, MARVIAN ature of Funeral Service DERRICK C. SONES, FIH 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. pproximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): The law requires that the death certificate be executed use as the burial-transit and Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No be detached for Day Year Pregnant at time of death Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy hours after death.

Ineral Director: After this certificate 1 🗌 Yes 2 🗌 No 1 ☐ Yes 2 🔀 No or Attending Physician: funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred | XNatural 5 \square Pending work? 1 ☐ Yes 2 ☐ No completed filled in by the Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) the Hospital within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

old

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 6. February KATHARINE SCHLEMM LENFESTEY 2012 1:15 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death KESWICK MULTI-CARE CENTER N/A Baltimore Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year Birthplace (State or Foreign Country) Days Hours 062-14-0092 **Director** 1 🗆 M 2 💢 F 96 Aug 30, 1915 Massachussetts Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location ral", or items 23a or 28a-f sho Examiner must be notified at Director N/AMaryland Baltimore 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 700 West 40th Street 21211 USA filed within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. þ 1 Never Married 2 Married 1 Yes If Yes, Give 2 **X** No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. "natural", Specify: White Completed 3 X Widowed 4 □ Divorced Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) iould be filed within 72 land Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) other traumatic event, the Homemaker Own Residence Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Schlemm Robert Marion Whitney should and Me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . Page 1 and 2 sl tment of Health a 27 Marion W. Bernard (Daughter) 836 Maple Lane, Waterville, Ohio item 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 🔲 Burial 2 💢 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory, Inc. 2/ 7/12 Baltimore, Maryland 21. Signatur of Fungral Servel 22.

Martin D. Lawson 22. Name and Address of Facility MITCHELL-WIEDEFELD FUNERAL HOME, IN 6500 York Road, Baltimore, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Promician) disease or condition Medical resulting in death) **Examiner** reprovascular Sequentially list conditions, trainy, leading to immediate cause. Enter Underlying Due to for as a sonsequence Exami Cause (Disease or injury that initiated events tran Due to (or as a consequence of): resulting in death) Last physician s the buria Physician/Medical requires that the death certificate be Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Pregnant at time of death Day Year 2 No 9 Unknown g Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law page 2 : certificate has performe Yes 2 No 2 X No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 2 X No 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1. Natural 5 Pending 1 Yes 2 No neral Director: A 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital of within 24 hours a To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Sertifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29c. License number 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) R177141 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Erica P. Warford, CRNP, GBMC, 6701 N. Calvert Street, Baltimore, MD 21204 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB 1 0 2012

DHMH 17 Rev 06-201

Registrar

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

		Plea			Print in						•			gible.		
		For State Registrar		State o	of Marylar		artmei <i>rtificat</i>			and N	/lental Hy	/gien Reg. N	_	n I	2_03	2775
Physicia Medic		Decedent's Name (First, Middle Robert Leberkn:									2. Date of De Month Febru	D	ay 9,20	Year) 1 2	3. Time o	
Examin			, give stre LOche		nber)			Town, or			10010			y of Deat		
Funeral Director		5. Social Security Number 217-38-1564 Usual Residence of Decedent	6. Sex 1	M 2 □ F	7. Age (In yrs. 74	last birthday) Yrs.	If Unde Months		If Under Hours	Min.	8. Date of Bi (Month, Da May 24	ay, Year)	37	Cot	thplace (State of untry) cyland	or Foreign
laryland 3a-f show iffied at	Director	10a. State 10b. County Md •			10c, Cir	ty, Town or Lo	ocation Balti	more							10d. Inside C	ity Limits
with the N 23a or 29 ust be not	Funeral Dir	10e. Street and Number 4800 Seton Di	rive		1			p Code 2121	5			10g. C		What Co JSA	ountry?	
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importants if time 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status 1 🛣 Never Married 2 🗌 Mar 3 🗍 Widowed 4 🗍 Divorced	ried	. Was Dece Armed Fo 1 Yes If Yes, Giv Year or Da	e ² X No		Was Dece If Yes, spe 1 Yes	cify Cubar	n, Mexican	i, Puerto	ecify Yes or No- Rican, etc.)			ck, White	rican Indian, e, etc. Vhite	
within 72 hou giene. er than "natu , the Medical	Completed	15. Decede (Specify only highe Elementary/Seconday (0-12) 10th				(Give life. E	dent's Usu kind of wo OO NOT us /A	ork done di		t of worki	ing	16b.	Kind of B	Business	Industry	
d be filed Mental Hyg arked oth atic event	To Be	17. Father's Name (First, Middle, I Max H. Leberk	,	t							e (First, Middle		Surnam	ne)		
id 2 shoul		19a. Informant's Name/Relations Dorothy Hunter	hip <i>(Typ</i> e,		ister		_				Point					0
it. Page 1 an rtment of He rtant: If iten njury or oth		20a. Method of Disposition 1X Burial 2 Cremation 4 Donation 5 Other (\$	Specify)	moval from	State	Place of Disponentery, cre	matory or o	other place neter	у	2-13	Date 3-2012	Par	kvil	lle,		-
Depar Depar Impor any ir		21. Signature of Funeral Service I						Bel:	air R	Road		imor			ral Hom 21206	e, Inc
Physician/ Medical Examiner		23a. Part 1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	complicationly one of	ause on ea	caused the dear ich line. In State (or as a conseq	1701	er the mod	de of dying	0	The	1/2	rrest,			Approxima Interval Bet Onset and	ween /
xecuted n and al-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last	b. c.		or as a conseq							,	***			
cate be ex physician the burial	edical		L d.													
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. within 24 hours after death. completed filled in by the funeral director, page 2 should be detached for use as the burial-trans	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	230	1 🔲 Live	come of pregna Birth 2 Fet nant at time of nown	al death 3	Ectopic Other (s	pregnancy pecify)	/					ate of del onth	,	Year
uires that the signed by ald be detacted	by	Part II. Other significant condition	ons contr	ibuting to d	eath but not res	sulting in the	underlying	cause give	en in Part	l.					the cause of c	
The law requate has bee page 2 shou	Completed										24a. Was auto perfi 1 \(\subseteq Yes	psy ormed2		prior to death?	topsy findings completion of c	available cause of
rsician: s certific director,	To Be (25. Was case referred to medical examiner? 1 Yes 2 No	Hos	spital:	Inpatient 2] EB/Outpatio	nt 2 🗆 D	Otho	r: /		only one) me 5 🗆 Resi			ou (Cnoo		
nding Phy ath. r: After this ie funeral c		27. Manner of Death 12 Natural 5 Pendir 2 Accident Investi		28a. Date	_ ·	28b. Time o injury		28c. Injury work?	at		28d. Describe				пу)	
tal or Atters as after de al Directo ed in by the	al Certificate	3 Suicide 6 Could 4 Homicide determ		28e. Place buildii	of Injury - At heng, etc. (Specif	ome, farm, st	eet, factor	y, office			28f. Location (City or To			er or Rur	ral Route Numl	oer,
the Hospii nin 24 hou the Funer npleted fill	Medical	29a. Certifier 1 Certifying (Check 2 Medical E only one) 13 Certifying	xaminer	: On the bas	is of examination	n and/or inves	stigation, in	my opinior	n, death od	curred at	the time, date	and plac	e, and du	e to the o	cause(s) and ma	unner stated.
P ₹ P 5		29b. Signature and title of certified	ent	tus			29	c. License	number / 33	75		29d. D.	/ _ /	201	n, Day, Year)	
78,		30. Name and address of person KAKTW W. M.	0 -4	77	6934	AVIA	Print)	Spot	VD	Su	ITEN-	12	Sc€	NB	DEDIT,	41
Stat Registra		31. Date filed (Month, Day, Year)	2012	2	egistrar's Signa	ba	Mes									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2012 Year Month Physician/ Gwendolyn L. Lewis February 8, Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Rockville Montgomery Casey House 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) If Under 24 Hrs. 5. Social Security Number **Funeral** Days **Director** 1 □ M 2 XF 415-68-0315 Jul 26, 1943 68 Tennessee Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location 10a. State must be notified at Director MD Montgomery Chevy Chase Of, Zip Code 10e. Street and Numbe 10g. Citizen of What Country? ō 23a Funeral USA 4512 Cortland Road 20815 "natural", or items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status traumatic event, the Medical Examiner Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Black, White, etc. 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) should be filed within 72 h and Mental Hygiene. College (1-4 or 5+) Elementary/Secondary (0-12) Higher Education 5+ Sociologist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ೭ Robert M. Lewis Glenna Parker 1 and 2 should be of Health and Mei item 27 is mark 19a, Informant's Name/Relationship (Type, Print) David Montgomery/husband injury or other 20a. Method of Disposition 1 ☐ Burial 2 🏅 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place permit. Page 1 a Department of H Important: If ite any injury or oth 4 Donation 5 Other (Specify) 21. Signat Funeral Service License 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Physician/ Liver Cancer Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Cause (Disease or injury sician and burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical certificate be IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 Yes 2 No Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Completed 24a. Was an has autopsy Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 1 🗌 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA မ 28a. Date of injury 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) X Natural injury 5 Pending 1 Yes 2 No Accident Investigation

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4512 Cortland Road Chevy Chase, MD 20815 20c. Location - City or Town, State Final Journey Crematory 02/11/12 | Woodbine, MD Coing Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville. MD MD 21029 Approximate Onset and Death Division of Vital Records, P.O. Box 68760 23d Date of delivery Day 23e. Did tobacco use contribute to the cause of death? Hospital or Attending Physician: The law requires 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 4 Nursing Home 5 Residence 6 Nother (Specify) hospice within 24 hours after death. To the Funeral Director: After Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined building, etc. (Specify) City or Town, State 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29d. Date signed (Month. Dav. Year) 29b. Signature and title 29c. License number R143201 2.9.12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Debrah Miller, CRNP 6001 Muncaster Mill Rd. Rockville, MD 20855 FEB 1 0 2012 31. Date filed (Month, 32. Registrar's Signature State Registrar DHMH 17 Rev 06-2011 ORIGINAL

9:10 P

10d. Inside City Limits

1 Yes 2 X No

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Mary Regina Lindenmeyer 10:32 Medical February 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Baltimore Towson Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day, Yea
Dec 2 1 7. Age (In yrs. last birthday, **Funeral** 9. Birthplace (State or Foreign 1 - M 2 X F Hours Mary Land 215-16-5723 **Director** Yrs. 89 Dec 1922 Usual Residence of Decedent or 28a-f show 10b. County 10a, State any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🙀 No Maryland Baltimore Timonium 10e. Street and Number 10f. Zip Code 10q. Citizen of What Country? 2300 Dulaney Valley Rd. 21093 USA Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Black, White, etc. 1 Never Married 2 Married Completed by ☐ Yes 2 🔀 No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 😾 No Specify: "natural", 3 √ Widowed 4 □ Divorced Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Insurance Clerk Hospital Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Robertson James Mary Frances Pilkerton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mark L. Lindenmeyer/ Son <u>3607 Hampshire Glen Ct. Phoenix,</u> MD. 21131 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Cemetery 2-13-12 Baltimore, MD. 21. Signature of Juneral Service Licenses and Address of Facility Ruck Towson Funeral Home, 1050 York Rd. Towson. md. 23a. Part 1. Enter the distance, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ 1 Schemic disease or condition resulting in death) AL Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 2 No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 **N**0 Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Natural 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗆 Homicide Medical

Box 68760 P.O. Records, To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica Division of Vital completed filled in by the funeral director,

> State Registrar

29a. Certifier

(Check

ess of person who completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ Eleanor Plugge Lipsitz 3:05 February Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Stella Maris Baltimore Timonium 5 Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign (Month. Dav. Year) 260-24-1816 Director 1 □ M 2 🛛 F 95 June 6, 1916 Maryland 23a or 28a-f show and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f sho aumatic event, the Medical Examiner must be notified at 10b. County 10c. City. Town or Location 10d. Inside City Limits Director Maryland Baltimore Baltimore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? $A \cdot M$ Funeral with 1 7300 B Park Heights Avenue 21208 U.S.A. death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black White etc. 1 Never Married 2X Married Completed by hours after 21215-0036 1 ☐ Yes 2X No Specify If Yes Give Specify 3 Divorced White Year or Dates 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Nurse State of Maryland Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Plugge Edward Elizabeth Gadow 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Eleanor J. Lipsitz Daughter 100 Church Lane Baltimore, Maryland Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Donation 5 D Other (Specify) Druid Ridge Cemetery 2-10-2012 Baltimore Maryland 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. nera Service 1050 York Road Towson, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final O set and Death Physici_n disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Segmentially list curulitions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death Month Year should be detached signed by the g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by Records, 1 \square Yes No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of this certificate has autopsy perform death? Yes Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) o 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Director: After the Hospital or Attending Natural Accider 5 Pending Division Accident Investigation filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours a Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one) 29b. Signature and title of certifier 0 19 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JUSTINE PREIS, CRNP 2300 DULANEY 2300 DULANEY VALLEY ROAD TIMONIUM 21093

DHMH 17 Rev 06-2011

Registrar

FEBRUARY

LIPSITZ,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ictor Martinez	State of Maryland / Department of Health 1- For State Registrar Certificate of Death	and Mental Hy		201 eg. No.	2 0377
Physician/ ledical Examine	1. Decedent's Name (First, Middle,Last)		Date of Dear Month	th Day Year	3. Time of Death 0120 hrs
	4a. Facility Name (if not institution, give street and number) 4b. City, Tow	vn, or Location of Death	February	4c. County of Death	
Funeral	Kernan Hospital Baltimo 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under		. 8. Date of Bir		hplace (State or
Director	214.21.3229 _{1 MM 2 F} 74 _{Yrs.} Months	Days Hours Min.	08.13	3.1937 Foreig	Equador
, any	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
ryland a-f show f ouce,	MD Baltimore 10e. Street and Number 10f. Zip Co	ode	F 44	0g. Citizen of What Cour	1 es 2 No
n the Marylanc 3a or 28a-f sh otified at onc		216		U.S.A.	u y :
leath with r items 23 unst be no	1 Never Married 2 Married Armed Forces? If Yes, specify C	of Hispanic Origin? (Sp Cuban, Mexican, Puerto		White, etc.	
ral", or		No specify: Ecu			
72 hour 72 hour 81 Exan	Elementary/Secondary (0-12) College (1-4 or 5+)	ig life. DO NOT use retir		16b. Kind of Business/In Education	
5-0036 lod within 72 hour 1/y giene. other than "natu the Medical Exact Completed	5+ Professor	18.Mother's Name	(First Middle M		011
D 21215-00; should be filed within and Mental Hygiene, 7 is marked other thatie event, the Med To Be Comi	Luis Martinez	Emma	Balsed	ca	
E 0 = 0 =				ber, City or Town, State, MD 2121	
nore, hages I and int of Health it: If item other trau	20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name crematory or other place)		Date	20c. Location - City or	
Baltlmore, permit. Pages I an Department of Hee Important: If ite injury or other tr	4 Donation 5 Other Specify: Chesapeake Cr 21 Signature of Funeral Service Licensee 22. Name and Ad			Beltsvill	
M 원리트 Physician	23a. Part I. Enfer the disease, or complications that caused the death. Do not enter the mode of d			ohen D. Lor. Balto.,	Approximate Interval
/Medical Examiner	failure. List only one cause on each line. Immediate Cause (Final disease a Complications of Multiple I		roop, alony arro	sa, onoan, or noan	Between Onset and Death
	or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, b.				
red misit	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated				
and transit	events resulting in death) Last Due to (or as a consequence of): d,				
e be execut ysician and burial - trai	☑ AMENDED 23a,pt.II,27,28a-f,p	er me,g925	3-23-12	sm	
	F FEMALE: 23b. Was decedent pregnant in the past 12 months?	3 Ectopic pregnan	псу	23d. Date of delivery Month D	ay Year
the death certificat by the attending phyched for use as the Physician/M	1 Yes 2 No 9 Unknown Pregnant at time of death 5 Other (Specify)				
P.O. s that the med by detach	Part II. Other significant conditions contributing to death but not resulting in the underlying care Hemophilia A	use given in Part I.		bacco use contribute to the	
Records, P.C. The law requires that ficate has been signed by page 2 should be deta	пешоринна д		24a. Was a	n 24b. Were auto	opsy findings available impletion of cause of
Records, The law require ficate has been si page 2 should b Completed			perform 1 Yes 2	med? death?	
To it is in the control of the contr	25. Was case referred to medical examiner? 1 ✓ Yes 2 No Hospital: 1 ✓ Inpatient 2 ER/Outpatient 3 DOA	Other Nursing		Residence 6 Other:	
	1 Natural 5 Reading (Month, Day, Year)	· · ·		owinjury occurred driver in a	an auto to
Division o spital or Attending nours after death. neral Director: Aft filled in by the fune Certification:	2 X Accident Investigation 1 Investigation 28e. Place of Injury - At home, farm, street, factory, off	ice building, etc.	28f. Location (St	Llision treet and Number or Rura ate Columbia P	Route Number, City
	4 Homicide determined (Specify) Roadway 29a. Certifier (Check only (Check onl	(Chaney F	Rd. Silver	Spring,MD.
To the Ho within 24 To the Fu completel	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opiand manner stated.	inion, death occurred at		nd place, and due to the	cause(s)
	4	.C.M.E.		29d. Date signed (Monte February 8, 2012)	n, ∪ay, Year)
The last	30. Name an laddr s of person who impleted cause of death (Item 23a) Pamela E. Southall, MD Assistant Medical Examiner 900 W. Baltin	nore Street Police	nore MD 24	223	
State	31. Date Tel Minital Dal Ada 32 Registrats Signature 900 VV. Baltin		IOIE, IVID 21.		

DHMH 17 Rev 1/2001 0CME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death 1 Decedent's Name (First Middle Last 2. Date of Death 3. Time of Death Physician/ Month Dav Vear 6:30 AM Arthur Miller February 6, 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 11623 Philadelphia Road Baltimore White Marsh 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Year) 87 Oct 19, Director 185-14-2806 1 M 2 D F 1924 Pennsylvania Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director must be notified 1 Yes 2 No MD Baltimore White Marsh 10e. Street and Number 10g. Citizen of What Country? items 23a Funeral 11623 Philadelphia Road 21162 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. 0 þ 1 Never Married 2 Married 1 Yes 2 □ No If Yes, Give 1 ☐ Yes 2 No Specify: "natural" 3 Widowed 4 ☐ Divorced Specify: Completed Year or Dates. WW White 15. Decedent's Education (Specify only highest grade completed) Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry than, Elementary/Secondary (0-12) College (1-4 or 5+) 8 Construction Mason is marked other Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည James Albert Miller Florence Myrtle Ashbaugh 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 any injury or other tra Lois Wilhelm /Daughter 131 Wengate Road Owings Mills, MD 21117 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 remation 3 Removal from State Feb 07 Beltsville, Maryland 4 Donation 5 Other (Specify) Chesapeake Crematory 2012 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Cremation and Funeral Alternatives 8717 Green Pastures Drive Towson Maryland 21286 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph.sician/ Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions Examine Due to jor as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events the burial-trai Due to (or as a consequence of) resulting in death) Last Physician/Medical as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ 23d. Date of delivery in the past 12 months? Month Pregnant at time of death Yes 2 No g Unknown 9 Unknown P.O. Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autonsy 2 No 1 Yes Yes Division of Vital To the Hospital or Attending Physician: director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 1 Yes 2 No ပု 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural Accident 5 Pending injury 1 Yes 2 🔲 No Investigation filled in by the after deatl 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide City or Town, State) within 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and tive pleted cause of death (Item 23a) (Type, Print) State Registrar

13

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items State of Maryland / Department of Health and Mental Hygiene 20 | 2 Certificate of Death Reg. No. 1. Decement's Name (First, Middle, Last) 2. Date of Death 11:51 A_M Month Physician/ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Emerald Estates Assisted Living Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Feb 27, Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Hours Min 382-18-0797 1 □ M 2 🗓 F Florida 1918 Director Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits within 72 hours after death with the Maryland 10c. City, Town or Location Director 1 X Yes 2 No <u>Baltimore</u> MD 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral USA 21211 3855 Greenspring Avenue #242 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces Black, White, etc. 1 Never Married 2 Married Yes 2 XNo Completed by Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: If Yes Give Specify: black 3 ₩ Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. healthcare nurses aide Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Rose Weatherford Atonie Weatherford permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic conce. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9400 Wordsworth Way #205; Owings Mills, MD 21117 19a. Informant's Name/Relationship (Type, Print) Jo Ann Karen Joseph - niece Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Funeral Service 22. Name and Address of Facility State Anatomy Board 21. Signat 21201 655 W. Baltimore St; Baltimore, MD . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or beart failure. List only one cause on each lin. Interval Between Onset and Death Immediate Cause (Final Physician/ end disease or condition resulting in death) Medical Due to (or as a const quence of) **Examiner** Sequentially list conditions, if any reading to immediate Examine cause. Enter Underlying Cause (Disease or linjury Due to for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Year Pregnant at time of death 1 ∐ Yes 2 9 ☐ Unknown No ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Hyperlipidemin 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2**X** N 1 Yes 2 No **Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Assisted Hospital: Other: 2 4 Nursing Home 5 Residence 6X Other (Specify) Living 1 Inpatient 2 ER/Outpatient 3 IDOA this funeral Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at s after death. I Director: After the 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No Natural 5 Pending Accident Investigation 6 Could not be within 24 hours after dear To the Funeral Director completed filled in by the Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Dertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the

Registrar DHMH 17 Rev 7/2009

State

29b. Signature

Name and address of person who completed cause of death (Item 23a) (Type

32. Registrar's Synature

rack

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Ralph Harmon Miller 4:45 February 201 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Worcestor Berlin Nursing Home & Rehab Berlin If Under 24 H Funeral If Under 1 Year 8. Date of Birth 9. Birthplace (State or Foreign 1 ₹ M 2 □ F Months Days Hours Min. 11-30-1921 235-26-6831 West Virginia **Director** 90 Usual Residence of Decedent or items 23a or 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shot any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c, City, Town or Location Director 10d. Inside City Limits Md. 1 Yes 2 X No Worcestor Berlin 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 21811 USA 9715 Healthway Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Specify: 3 X Widowed 4 Divorced Year or Dates. 1942-1946 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) <u>Steel Worker</u> Steel Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ᅙ Roy H. Miller Lucy Mann 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Viola J. Zimmerman DTR. P.O. Box 3243 Ocean City, Md. 21843 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Suburial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Gardens of Faith 2-10-2012 Balto. Md. 21. Signature of Funeral Service Licensee Schimunek Funeral Home, 22. Name and Address of Facility 9705 Belair Road Nottingham, Md. 21236 23a. Part 1. Enter the disea shock, or heart fail complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death List only one cause on each line. Immediate Cause I al Physician/ disease or condition Medical resulting in death) Due to (or Examiner las Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (a To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 1 Yes 2 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 2 1 No 1 Tyes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: မ 1 🗌 Yes 2 400 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Latural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 🗌 Yes 2 🗌 No Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| Certifying Nurse Practioner: To fine best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one) 29b. Signature and title of ce 29d. Date signed (Month, Day, Year) 12 6 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar William Robins,

31. Date filed (Month, Day, Year)

ller

9715 Healthway Dr, Berlin,

21811

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death ^{Day} 2012 **Physician** February 2:20 P M Marian Nosal /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** N/A **Baltimore** Future Care Irvington If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 12/01/1953 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2 □ F 58 Poland 213-11-1128 Director Usual Residence of Decedent be filed within 72 hours after death with the Maryland ntal Hyglene. 10c. City, Town or Location 10d. Inside City Limits 10a. State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, I'm "holical Evanirer" ast be ruffled at 1 ☐ Yes 2 ➡ No Directo Glen Burnie Anne Arundel Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 21061 7948 Oakwood Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 2 XNo 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify: White 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) Carpenter Home Improvement 12 should be filed w h and Mental Hygiei 7 is marked other th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Bronislawa Kubacka Jan Nosal ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 sh Department of Health and Important; If item 27 is n any injury or other traunonce. 7948 Oakwood Road Glen Burnie, Maryland 21061 Anna Rolinska – Friend 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 02/10/2012 Glen Burnie, Maryland Atlantic Crematory 4 □ Donation 5 □ Other (Specify) David J. Weber Funeral Homes P.A. 401 S. Chester Street Baltimore, Maryland 21231 21. Signature of Funeral Service Approximate Interval Between Onset and Death 23a. Part 1 Enter the disease, or commodation is that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List on one cause on each line. Immediate Cause (Final Physician ENCEPHALOPATHY ANOXIC disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner **JETASTATIC** Sequentially list conditions, if any, leading to infilineurate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine the burial-transi RESPIRATORY FAILURE CHRONIC attending physician and for use as the burial-trar Due to (or as a consequence of) Box 68760 certificate be Physician/Medical for use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav 4 ☐ Pregnant at time of death 5 ☐ Other (specify) signed by the a P.0. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown cate has been si page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 □Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 2 No 4XNursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred spital or Attending P nours after death. neral Director: After y filled in by the funer 1 Natural 2 Accident Injury 5 Pending 1 □Yes 2 □ No investigation 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier IMM D71264 2012 30. Name and address of person who completed ause of death (Item 23a) (Type, Print) uzo unegbu, mo P. O.BOX SAUSBURY MD. 21802-2613 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		-	State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 0 1 2	2 03784
P	hysicia	_	1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day, Ye	
	/Medic Examin	al er	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of D 1000 Ryleview Prive, Silver Spring Monte	eath yo mevy
	ineral rector		Months Days Hours Min. (Month, Day, Year)	Birthplace (State or Foreign Country) Brazil
Maryland	-f show	tor	10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits 1 ☐ Yes 2 XNo
with the	3a or 28e st.be.roti	Funeral Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What 20910 USA	Country?
:1215-0036 within 72 hours after death with the Maryland ene.	is marked other than "neturel", or items 23a or 28e-f show eumatic event, the Madical Exeminer must be notified at	þ	3 Widowed 4 privorced If Yes, Give 1 to 10 also:	American Indian, White, etc. Thite
Maryland 21215-0036 Id 2 should be filed within 72 hours af	r than "neture the Medical E	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Silver Smith 16b. Kind of Busine Silver Smith	ess/Industry
land 2	rked other tic event,	To Be C	17. Father's Name (First, Middle, Last) Amanda Bisordi	
Mary nd 2 shoulth and N	27 is ma r treuma		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Star Esmeralda Paci/Wife 809 Silver Spring Ave. Silver Spring, N	
Baltimore, permit. Pages 1 ar Department of Hea	Importent: If item 27 is marked eny injury or other treumatic ev QBGe.		20a. Method of Disposition 1 Disposition 1 Disposition 1 Disposition 1 Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Parklawn Mem. Cem. 20c. Location - City Parklawn Mem. Cem. 20c. Location - City Rockville.	, MD
Balti permit. Departm	Importe eny inju once.		21. Signature of Funeral Service Licensee **LOISTS** 22. Name and Address of FacilityRapp Funeral & Crema 933 Gist Ave. Silver Spring, MD 209	ation Services 910
Exa	opphysician and as the burial-transit as the burial-transit	dicai Examiner	d	Approximate Interval Between Onset and Death
Division of Vital Records, P.O. Box 68: To the Hospitel or Attending Physicien: The law requires that the death certificat within 24 hours after death.	been signed by the attending phy should be detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	delivery Day Year
ds, P	signed b	d by Pł	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 E	te to the cause of death? Probably 4 Munknown
Division of Vital Records, P.O. for Attending Physicien: The law requires that the dafter death.	cate has beer , page 2 shou	Completed by		e autopsy findings available to completion of cause of th? Yes 2 \(\sum \) No
of Vita	nis certifi I director	To Be	examiner?	Specify)
ion o nding P!	r: After the funeral			
Divis el or Atte s after de	ol Directo ad in by th	Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number of City or Town, State)	r Rural Route Number,
he Hospit in 24 hour	To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical (due to the cause(s)
To t	Tot	N		
	6		Raul A. DEVORE MD4203 Queensbury Rd Hyatts Ville MD 2	20781
Th.	Sta Registi		31. Date filed (Month, Day, Year) 324 Hegistrar's Signature	

12-01003

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Œ	Type of Fillicial big	ICK IIIGGIIDIG IIIK:	Liisui e Aii	oobies vi
	State of Manyland /	Department of He	alth and Me	ntal Hygier

2	0		2	0	3	7	8	2
6	U	Į.	£	-	الهاية	- 1	\cup	1

arrison Roberts		State of Maryland / Department Certificate Certificate		a Mentai riyg		2. No.	2. 0010
Physicia	in/	Registrar 1. Decedent's Name (First, Middle,Last) HARRISON MARSHALL RO	OBERTSON		Date of Death Month ebruary 2,		3. Time of Death 2123 hrs
™GICAI EXAIIII		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or I		redition 2,	4c. County of Death	<u> </u>
Formul		Union Memorial Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Baltimore) If Under 1 Year	If Under 24Hrs.	3. Date of Birth	N/A	
Funeral Director		217-50-2658 1XM 2□F 55	Yrs. Months Days	1.0	Mar 23,	Foreig	
any	H	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo					10d. Inside City Limits
Maryland 28a-f show d at once.	ţ	Maryland N/A Baltimon	re 10f. Zip Code		110	g. Citizen of What Cou	1 X Yes 2 No
with the Maryland us 23a or 28a-f sho be notified at once	Dire	116 West University Parkway	21.	210		USA	
hours after death with the Maryland natural", or items 23s or 28s-f she Examiner must be notified at once	Funeral	1 X Never Married 2 Married Armed Forces? 1 Yes 2 X No	Was Decedent of Hisp If Yes, specify Cuban,	, Mexican, Puerto Ri		White, etc.	ican Indian, Black,
urs after tural",		15. Decedent's Education (Specify only highest grade completed) 16a. Decedent	Yes 2 X No dent's Usual Occupation	ion (Give kind of wor		Specify: Who	
2 -	Completed by	Elementary/Secondary (0-12) College (1-4 or 5+)	g most of working life. $\mathrm{N/A}$	DO NOT use retired)	N/A	
		17. Father's Name (First, Middle, Last) Harrison M. Robertson, Jr.	1	18.Mother's Name (F Margare		aiden Surname) Watmou	ıch
2121 ould be fi Mental marked ic event,	To Be	19a. Informant's Name/Relationship (Type, Print) (Father) 19b. Mai		t and Number or Run	al Route Numb	per, City or Town, State	, Zip Code)
MD and 2 sho alth and 27 is raumat			Seagate R			, Florida 3	
Baltimore, MD 2121 pernit. Pages I and 2 should be fil Department of Health and Mental Important: If item 27 is marked injury or other traumatic event,		1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other Specify:	crematory		2012	Baltimore	, Maryland
Balt permit. Departr Import						L HOME, INC , Maryland	
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter failure. List only one cause on each line.				st, shock, or heart	Approximate Interval Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death) a. Atherosclerotic Car Due to (or as a consequence of):	atovascur	ar Diseas	е		
	ē	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):					
	Examiner	(Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of):					1
executed an and al - trans	Wedical E	d. Suppended Amended #1 per me, g9 23a, 27, per me, g925	24,02/10/2	2012dhb			
760, cate be physicii	/Med	IF FEMALE: 23c. If yes, outcome of pregnancy				23d. Date of deliver	
Box 68760, death certificate be executed the attending physician and of for use as the burial - transit	Physician/	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 1 Unknown	Fetal death 3 L Other (Specify)	Ectopic pregnanc	y 	Month I	Day Year
O. B. at the de 1 by the tached f		Part II. Other significant conditions contributing to death but not resulting in the	ne underlying cause g	iven in Part I.		pacco use contribute to	Contract Con
ords, P.O. w requires that the same of the	ed by			_	1 Yes	2 No 3 Prol	topsy findings available
Cord	Completed				autops perform	y prior to oned? death?	completion of cause of
tal Rection: The certificate ector, page	Be Co	25. Was case referred to medical		of Death (Check onl		NO I I	2 10
f Vit Physici er this c	F	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpati 27. Manner of Death	icite o Boxt	Other Nursing Nursing I		Residence 6 Othe	r:
ion of tending Pheath.	tion	1 Natural 5 Pending (Month, Day,Year)		res 2 No			
Division of Vital Records, begins or Attending Physician: The law requirments after death. Ineral Director: After this certificate has been siy filled in by the funeral director, page 2 should it.	Certification	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) 28e. Place of Injury - At home, farm, s	street, factory, office be	uilding, etc. 28	or Town, Sta		ural Route Number, City
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Medical C	29a. Certifier (Check only one) CertifyIng Physician: To the best of my knowledge, death or one) Wedical Examiner: On the basis of examination and/or invest	ocurred at the time, da tigation, in my opinion,	ate and place, and du , death occurred at the	ue to the cause ne time, date a	e(s) and manner as state and place, and due to the	ed. ne cause(s)
To vii	We	29b. Signature and title of certifier	29c. License			29d. Date signed (Mo	
plea		30. Name and address of person who completed cause of death (Item 23a)	O.C.M	VI.E.		February 4, 2012	۷
pend		Pamela E. Southall, MD Assistant Medical Examiner	900 W. Baltimor€	e Street, Baltime	ore, MD 21	223	
Si Regis	ate trar	31. Date filed (Month, Day, Year) 62. Registrar's Signature FEB 1 0 2012	No.				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Physician/ 7:10 P M 2012 31 June Elizabeth Rice January Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Anne Arundel Odenton 212 Odenton Road Apt. 423 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Social Security Number **Funeral** Months Days Hours 124-38-4320 1 □ M 2 🛛 F **Director** 4-25-1935 England 76 Usual Residence of Deced 28a-f shov 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County should be filed within 72 hours after death with the Maryland Director peilified 1 Yes 2 No Odenton MD Anne Arundel 10f. Zip Code 10g. Citizen of What Country? Ь 10e. Street and Numbe must be 23a Funeral 21113 1212 Odenton Road Apt. 423 England 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, as Deced rmed Forces? Ves 2X No Black, White, etc ò ş 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Completed 3 X Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Safeway h and Mental Hygier 7 is marked other t Secretary Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Nellie Price <u>Harold Reyn</u>olds 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. 15305 Briarcliff Manor Way Burtonsville, MD 20866 Joan Wessel / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 X Cremation 3 Removal from State Arundel Crematory 2-5-2012 Odenton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Donaldson Funeral Home & Crematory, P.A.
Donaldson Funeral Home & Crematory, P.A.
Donaldson Funeral Home & Crematory, P.A. of uneral Service Livense 1411 Annapolis Road Odenton, Maryland Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Onset and Death minutes Immediate Cause (Final Physician/ Cerebrovascular Accident disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** years Carotid Stenosis Jequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury quentially list conditions, Examiner Due to (or as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl for use as t IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Dav 5 Other (specify) Pregnant at time of death Yes 2 X No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Type 2 DM, Hyperlipidemia, Hypertension 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X No 1 ☐ Yes 2 X No 26. Place of Death (Check only one) 25. Was case referred to medical Be Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 ☐ Yes 2 🗓 No 1 Inpatient 2 ER/Outpatient 3 DOA မ 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred X Natural 5 Pending Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Suicide 28f. Location (Street and Number or Rural Route Number, 4 Homicide Certifying Physician to the Dest of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 06-2011

29b. Signature and title

Danny Lee, M.D.

certifier

T 0 2012

1132

leted cause of death (Item 23a) (Type, Print)

32. Registrar's Signat

29c. License number

Annapolis Road Odenton, Maryland 21113

D54853

February 3, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 | 2 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ February 5, 2012 9:12 P_{M} Lee Ann Ranieri Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner BelAir Harford Upper Chesapeake Medical Center Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Director 220-34-5071 70 1 44 2 X F 07/14/1941 Maryland Usual Residence of Decedent 28a-f show 10a. State 10b. County 10d. Inside City Limits aţ 10c. City, Town or Location Director notified 1 Yes 2 X No Maryland Harford Aberdeen ō 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? items 23a or ner must be n Funeral 21001 USA 533 Windemere Drive 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. o by 1 Never Married 2x Married 1 Yes 2 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 Yes 2XXNo Specify: Specify: white "natural", Completed 3 Widowed 4 Divorced Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the Restaurant Business owner Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Lee Austin Miller MaryAnn Wilson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trainonce. 533 Windemere Dr., Aberdeen, MD 21001 Anthony Ranieri (husband) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition 1XXBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hill Cemetery 2/9/2012 Havre de Grace, MD Furera Service 22. Name and Address of Facility Tarring-Cargo Funeral Home, P.A. 21. Signature <u> Aberdeen, Maryland 21001</u> 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Ph_sician/ disease or condition resulting in death) das Medical Due to (or as a consequence **Examiner** Sequentially list conditions, if any, leading to minimisculate cause. Enter Underlying Cause (Disease or injury Examine Data to Carea a correspondence of and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician a for use as the burial-Physician/Medical death certificate be 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Box 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Day Pregnant at time of death 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💥 Unknown Completed 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of perform death? 1 Yes 2 No Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 1 Tyes မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) Division of 27. Manner of Death 28b. Time of 28a. Date of injury Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 2 Accident 5 Pending work?
1 Yes 2 No n 24 hours after death.

e Funeral Director: Aft bletely filled in by the ful M Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined City or Town, State) Hospital Medical 29a. Certifier 1 🔏 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F only one) 29b. Signature a 29c. License number 29d. Date signed (Month, Day, Year) February 6, 2012 DO053568 Beldi March 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 101 1 effrei 7D MORPSON 31. Date filed (Month, Day, Year) State Registrar

m80029063

100 i 100

RAN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 7:20 PM Fedir Stepanov February 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Sinai Hospital of Battimore Baltimore Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 03/23/1939 Ukraine Director 731-05-3028 1 🔀 M 2 🗆 F 72 10d. Inside City Limits death with the Maryland 10a. State 10b. County 10c. City, Town or Location Director r 28a-f sl notified 1 X Yes 2 No Owings Mills MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō ms 23a or must be r Funeral Ukraine 21117 3420 Associated Way #421 Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 XMarried 1 ☐ Yes 2🙀 No If Yes, Give within 72 hours after 21215-0036 1 ☐ Yes 2 No Specify. Specify: White Completed 3 Widowed 4 Divorced Year or Dates. 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Private Bus Driver 7th is marked other aumatic event, the Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Stepanida (unk) Konstantin Antonovich Stepanova 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
7 Supreme Court, Owings Mills, MD 21117 Irene Slootsky (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page 1
Department of Important: If it any injury or o once. 1 Burial 2X Cremation 3 Removal from State 2/11/2012 4 Donation 5 Other (Specify) Hanover, MD Ardent Cremation 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Latimore Funeral Services, PA 2818 E. Baltimore Street, Baltimore MD 21224 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ renal cell carcinoma Metastatic disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions Examine Due to (or as a consequence of) if any, leading to immediate To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury physician and s the burial-trans that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: asn 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 2 No 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autons performed?/ Yes 2 12 No death? 2 🗌 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? HOSPICE 2 **V** No Hospital Other: 1 Tyes ဂ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Natural injury 5 Pending Accident Investigation the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, ☐ Homicide determined within 24 hours a

To the Funeral D Medical 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 06-201

Vivek Kalia,

FEB 1

31. Date filed (Month, Day, Year,

MD

2012

Stepanov,

Baltimore,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sinai Hospital of

32. Registrar's Si

P26514

February, 9, 2012

2401 W. Belvedere Ave, Baltimore, MD 21215

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Physician/ Month Flora Mae Slater 30 .2012 2:50a Medical January 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Prince Georges' Cheverly Hospital USA Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Min Director 577-36-1264 1 🗆 M 2 🔀 F 85 06/16/1926 South Carolina Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits other traumatic event, the Medical Examiner must be notified at Director 1 X Yes 2 No PG MD Upper Marlboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a Funeral 520 Harry S. Truman Drive 20774 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 1 Never Married 2 Married à Yes 2 No Baltimore, Maryland 21215-0036 72 hours after 1 ☐ Yes 2 ☐ No Specify: Specify: Black "natural", Completed 3 🖵 Widowed 4 🗌 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 8th Domestic Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George Rogers Pansy Benjamin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is Theresa Cox/Daughter 5618 Onslow Way; Capitol Heights, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 5 injury o Lincoln Cemetery 02/07/2012 | Brentwood, Maryland f Fi neral Service Licenses 22. Name and Address of Facility Freeman Funeral Services any Beech Road: Temple Hills, MD 23a. Part 1. Enter the disease, or complishock, or heart failure. List only one Immediate Cause (Final s that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death . Ph. sician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions Examine Due to (o if any, leading to immediate cause. Enter Underlying as a consequence of Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ ate has been signed by the atte page 2 should be detached for in the past 12 months?
1 Yes 2 No Year Dav Pregnant at time of death Unknown 9 Unknown ributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law autopsy certificate has Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: Other: 2 X No 1 🗌 Yes ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: (Month, Day, Year) 5 Pending Natural Accident s after death. 1 🗌 Yes 2 🗌 No Investigation completely filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined building, etc. (Specify) within 24 hours a To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 10 BM Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 06-2011

State

3001 Hospital Drive

Chéverly, Maryland 20785

Dementrios James Catevenis

Day, Year

1 0 2012

	1	For State Registrar		Int in Black Maryland / De Co		Health and	Mental Hyo	-	2 0379
Physician Medica Examine	П	1. Decedent's Name (First, Mic Stanle 4a. Facility Name (if not institut Union Memo	ey L. Sines		4b. City, Town,	or Location of Deat		4c. County of De	
Funeral Director		5. Social Security Number 213-24-604 Usual Residence of Deceden	6. Sex 7. A	ge (In yrs. last birthda) 83 Yrs.		r If Under 24 Hrs	8. Date of Birt (Month, Day Oct. 1	h, Year) 9. E	Birthplace (State or Foreign Country) MD
Maryland 28a-f show otified at	rector	10a. State 10b. Cour		10c. City, Town or Mid	ocation dle Riv	er			10d. Inside City Limits
with the	Funeral Director	10e. Street and Number 312 Gro	ovethorn Ro	ad	10f. Zip Code	21220		10g. Citizen of What 0	Country?
°9	≥	11. Marital Status 1 ☐ Never Married 2 ☐ N 3 ☐ Widowed 4 🎛 Divorce	If Ven City	?	. Was Decedent of If Yes, specify Cu 1 Yes 2X N	Hispanic Origin? (S ban, Mexican, Puer No S <i>pecify:</i>	pecify Yes or No- to Rican, etc.)	14. Race - An Black, Wh Specify ₩ h	nite, etc.
within 72 hours after giene. er than "natural", o, the Medical Exam	Completed		dent's Education ghest grade completed) College (1-4 or	(Giv 15+)	edent's Usual Occi e kind of work done DO NOT use retire nager	e during most of wo	rking	16b. Kind of Busines Auto	s/Industry
land be filed fental Hy rked oth tic event	10 Be	17. Father's Name <i>(First, Middle</i> Lester E					me (First, Middle, I 7a Mae]		
Widtyldild 12 should be filed alth and Mental Hy 27 is marked off r traumatic even		19a. Informant's Name/Relatio	nship <i>(Type, P</i> nint) ermiller/da	ugher 19b. Ma	iling Address (Stree	et and Number or Ri vthorn I	ural Route Number Road Ba	; City or Town, State, I ltimore I	Zip Code) MD 212 20
Daltillore, bernit. Page 1 and bepartment of Hea mportant: If item any injury or other ance.		20a. Method of Disposition 1 🛣 Burial 2 🗌 Crematic 4 🗎 Donation 5 🗎 Other	on 3 Removal from Stat	e 20b. Place of Dis cemetery, cr Holly	ematory or other pi	metery 2		20c. Location - City of Baltimo	ore MD
Dal permit Depar Impor any in		21. Signature of Funeral Service	ely Comes	4 h		lly Fune	ral Hom	e Ave. Ba ne of Ess	
Physician/ Medical		23a. Part 1. Enter the disease, shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death)	a. Con	ed the death. Do not ene. Arany Arany Arange of:	ter the mode of dy	_	c or respiratory arr	est,	Approximate Interval Between Onset and Death
Examiner of the state of the st	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as	s a consequence of):					
te be executed lysician and he burial-transit	<u>8</u>	resulting in death) Last	Due to (or as	s a consequence of):					
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transity.		F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		2 Fetal death 3 at time of death 5	☐ Ectopic pregna☐ Other (specify)	ncy		23d. Date of c	delivery Day Year
requires that the despensioned by the should be detached	<u>}</u>	Part II. Other significant cond	itions contributing to death	but not resulting in the	underlying cause	given in Part I.	A.	/es 2 □ No 3 □	to the cause of death? Probably 4 Unknow
The law requires rate has been signate page 2 should b	palaiduion						24a. Was a autop perfor 1 Yes	sy prior to rnyed2 death?	autopsy findings available ocompletion of cause of es 2 \Boxed No
g Physician: T ter this certifica neral director, to Do C		25. Was case referred to medic examiner? 1 Yes 2 No	Hospital: \	tient 2 ER/Outpat	10	Place of Death (Chether: $4 \square$ Nursing I		ence 6 Other (Spe	ecify)
ial or Attending Phrasal Director: After this ed in by the funeral		3 Suicide 6 Cou	stigation ild not be 28e. Place of Ir	ay, Year) injury jury - At home, farm, s	M 1 [ury at ork? ☐ Yes 2 ☐ No	28d. Describe ho	ow injury occurred	
To the Hospital or Attency within 24 hours after death To the Funeral Director. completely filled in by the	Medical Ce	29a. Certifier 1 Certify (Check 2 ☐ Medica	ing Physician: To the best of Examiner: On the basis of	examination and/or inv	estigation, in my opin	nion, death occurred	and due to the car at the time, date ar	n, State) use(s) and manner as	stated. e cause(s) and manner stat
To the within 2 To the comple		only one) 3 Certify 29b. Signature and title of certi	1. /	he best of my knowledg		it the time, date and place number 2438		ne cause(s) and manner $29d$. Date signed (Mor $2/6/12$	
7 Bh		30. Name and address of person	on who completed cause of Hui, 500		Print)	Pkny	Baltimo.	m, MO.	21260
State Registrar		FEB 1 0 201	32. Regist	rar's Signature					
DHMH 17 Rev 06-20	11			ORIG					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		-	For State	State of Ma	aryland		artment of tificate of				7	012	03791
			Registrar 1. Decedent's Name (First, Middle, Last)			Cer	uncate or	Dealli		2. Date of Dea	Reg. No. 🦾 ath	. () 1 1	3. Time of Death
	Physicia		Francis	J.	Sw	eeney	Jr.			Month Februar	v 2.	201^{Year}_{2}	5:15 p.™
	Medic Examin		4a. Facility Name (if not institution, give stre	et and number)		=	4b. City, Town,	or Location			-	ounty of Deat	
man and			Tanicam Gentle Care				Laurel					ince G	
	Funeral		5. Social Security Number 6. Sex		(In yrs. las 7 3	st birthday) Yrs.	If Under 1 Year Months Days		er 24 Hrş, Min.	8. Date of Birt May 29		Co	thplace (State or Foreign untry) hington, DC
	Director		214-36-2697 Usual Residence of Decedent							riay 25,	, 1750	- was:	illigion, be
	/land f shov d at	tor	10a. State 10b. County			Town or Loc	eation						10d. Inside City Limits
	Mary 28a- notifie	Jirec	MD Prince Geo	orges	Lau	rel	1404 77 0 1						1 ☐ Yes 2 ☐ No
	ith the	Funeral Director	10e. Street and Number 8511 Portsmouth Dr				10f. Zip Code 20708					n of What Co	
	ems arr mus	nue		Was Decedent Ev	ver in U.S.	13. V	Vas Decedent of	Hispanic C	Origin? (Spe	cify Yes or No-	14	. Race - Ame	erican Indian,
9	fter de , or it amine	by F	1 ✓ Never Married 2 ☐ Married	Armed Forces? 1 Yes 2XXII If Yes, Give	No	- 1	Yes, specify Cul			Rican, etc.)		Black, White ecify: Wh	
8	ours a	Completed by	3 Widowed 4 Divorced	Year or Dates.					.y.			-	
15	72 hc in "na Medic	nple	15. Decedent's Education (Specify only highest grade of	completed)	,	(Give F	lent's Usual Occu kind of work done O NOT use retired	during mo	ost of workir	ng	16b. Kind	l of Business	Industry
212	within giene er tha , the		Elementary/Seconday (0-12)	College (1-4 or 5-	+)	Part	time Cle	rk			Libr	ary	
nd	filed tal Hy ed oth event	To Be	17. Father's Name (First, Middle, Last)							e (First, Middle, g ett W:			
<u>ya</u>	should be file n and Mental I 7 is marked o raumatic eve	-	Francis J. Sweeney	D-i-4)									0.11
Ma	2 sho Ith and 27 is i	ĺ	19a. Informant's Name/Relationship (Type, Robert L. Sweeney	(brot	her)		g Address <i>(Stree</i> N.W. 83						
ē,	1 and of Hea item other		20a. Method of Disposition	•	20b. Pla	ace of Dispo	sition (Name of natory or other pl			Date	-	ation - City or	
<u>E</u>	Page nent c ant: If ury or		1 ☐ Burial 2XXCremation 3 ☐ Red 4 ☐ Donation 5 ☐ Other (Specify)	noval from State	Ches	sapeak	e Cremat	ory	02/07	7/2012	Belt	sville	, Maryland
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Sign to re une al Service Licensee	МО	0982	²² 93	Name and Add	ress of Fac	Silve	Funer Sprin	al & g, Ma	Cremat ryland	ion Service 20910
			23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one complete the complete shock is the complete shock of the complete shock in the complete shock is the complete shock in the complete s	tions that caused	the death								Approximate Interval Between
Su.	Physician/		Immediate Cause (Final disease or condition	PARKIN		DEME	NTIA						Onset and Death
	Medical Examiner		resulting in death)	Due to (or as a	conseque	ence of):							
		Jer	Sequentially list conditions, if any, leading to immediate	Due to (or as a	conseque	ence of):							
K	d d ansit	amir	Cause (Disease or iinjury that initiated events c.										
N	ate be executed hysician and the burial-transit	dical Examiner	resulting in death) Last	Due to (or as a	conseque	ence of):							
90	physic the bu	dic	d.										
687	certific Iding I Ise as	Ň,	IF FEMALE: 23b. Was decedent pregnant 23c	. If <u>ye</u> s, outcome o							23	d. Date of de	livery
Box 687	ss that the death certific igned by the attending p be detached for use as	Physician/Me	in the past 12 months?	4 Pregnant at			Ectopic pregna Other (specify)	ncy				Month	Day Year
P.O. E	t the d by the tacher	Phys	g 🗌 Unknown	g ∐ Unknown						T			
<u>. </u>	es tha	by	Part II. Other significant conditions contributed SCHIZOPHRENIA	buting to death bu	it not resu	liting in the u	ndenying cause (given in Pa	irt I.				o the cause of death? Probably 4X Unknown
rds	require been si should	etec								24a. Was			topsy findings available
ecc	e law e has l ge 2 s	Completed by	UROSPSIS	A COTDENS						autor perfo	osy	prior to death?	completion of cause of
<u>س</u>	an: Th tificate tor, pa	Be C	CEREBOVASCULAR 25. Was case referred to medical	ACCIDENT			26.	Place of De	eath (Check	only one)			s 2 No
Χİţ	nysicia iis cer direct	To B	examiner? 1 Yes 2 No	pital: 1 ☐ Inpatie	ent 2 🗆 E	ER/Outpatier	nt 3 🗆 DOA	ther: 4 🗆	Nursing Ho	me 5 🗆 Resid	dence 6X	Other (Spec	ASSISTED bifyLIVING
10	ing Pl		27. Manner of Death 1X Natural 5 □ Pending	28a. Date of injur (Month, Day,		28b. Time of injury		ork?		28d. Describe h	ow injury c	ccurred	
sior	ttend death stor: A	Certificate:	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injur	n/ - At hor	me form stre		Yes 2	_	28f Location (S	Street and A	dumbar or Pu	ıral Route Number,
Division of Vital Records,	al or A s after I Direct		4 Homicide determined	building, etc			_		ļ	City or Tou		tarribor or ria	rui riodio ruiriooi,
_	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transi completed filled in by the funeral director.	Medical		On the b	mination	and/or invest	tigation, in my opi	nion, death	occurred at	the time, date a	ind place, a	nd due to the	cause(s) and manner stated.
	To the within 2 To the comple	ž	only one) 3 Certifying Nur.	e	pest of my	knowledge, o		the time, da				nd manner as signed (Mont	
	->-0		> WHICK	~			D 000)532	35			2/6/1	
	2		30. Name and address of person who com				Print)			00=5=		1011	
	0		DARYL HILL M.D., 31. Date filed (Month, Day, Year)				VE., LA	UREL,	MD	20707			
	Stat Registra		FEB 1 0 201	2 32, registre	s signati	8. b	arkel						
-													

12-01064 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Raymond Scheufele State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ 0427 hrs Medical Examiner February 5, 2012 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 3200 James Street **Baltimore** 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY 9. Birthplace (State or **Funeral** Months Days Hours Director Country) 1 M 2 F Usual Residence of Decedent 10b. County IOc. City, Town or Location 10d. Inside City Limits \$h0₩ 1 Yes 2 No Pages 1 and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene.

Int: Hitem 27 is marked other than "natural", or items 23a or 28a-f sho Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Street 200 Funeral 12. Was Decedent Ever in U.S. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 Married Yes Yes Yes, Give Year or Dates: 3 Widowed 1 Yes 2 No specify: 4 Divorced Specify: WhiTe 2 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed College (1-4 or 5+) Elementary/Secondary (0-12) Baltimore, MD 21215-0036 NA 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Hook ဥ (Street and Num or or Rural Route Number, City or Town, State, Zip Code) t: If item 27 is other traumat MALVERN 20b. Place of Disposition (Name of cemetery, 2 Cremation 3 Removal from State Donation 5 Other Specify: rem Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock/or heart **Physician** failure. List only one cause on ach line. Between Onset and /Medical aAtherosclerotic Cardiovascular Disease Death Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause Examiner Due to (or as a consequence of) (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) and Physician/Medical AMENDED 23a, pt. II, 27, per me, g926 4-12-12 sm UNPENDED the attending physician ed for use as the burial -Records, P.O. Box 68760 IF FEMALE 23d. Date of delivery 23c. If yes, outcome of pregnancy 3b. Was decedent pregnant in the 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown certificate has been signed by ector, page 2 should be detach Part li. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 Yes 2 No 3 Probably 4 V Unknown Chronic Alcoholism Completed Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? director, page ✓ Yes 2 No 1 Yes 25. Was case referred to medical 26.Place of Death (Check only one) Division of Vital Be examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other: Scene this 1 Yes 28a. Date of Injury (Month, Day, Year) After 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural 5 Pending 1 Yes 2 No 2 Accident Investigation 28e, Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 6 Could not be Suicide determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifie 29c. License number O.C.M.E. OGME.

Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 Theodore M. King, Jr., MD.

31. Date filed (Month, Day, Year) State FEB Registra

ORIGINAL

29d. Date signed (Month, Day, Year)

February 5, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year 15:05 PM **Physician** STEVEN SIZEMORE FEBRUAR 2012 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Johns Hopkins Bayview Medical Center **Baltimore** 8. Date of Birth (Month, Day, Year) 10-8-1952 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** Months 212-60-9433 Maryland 59 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natura!" any injury or other traumatic event. 10d. Inside City Limits 10a. State 10b County 10c. City, Town or Location 1 ☐ Yes 2 XNo Director Md. Balto. Fort Howard 10f. Zip-Code 10g. Citizen of What Country? 10e. Street and Number 9214 North Point Road 21052 USA Funeral Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X No Specify White þ Specify: 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Accountant Royal Farms 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Leo E. Sizemore Sylvia Tyson ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Mary Sizemore Spouse 9214 North Point Road Fort Howard, Md. 21052 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 XCremation 3 Removal from State 2-12,2012 Glen Burnie, Md. 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 12-12,2012 | Stem 2011 | 22. Name and Address of Facility Schimunek Funeral Home, Inc. 21. Signature of Funeral Service Licensee 9705 Belair Road Nottingham, Md. 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Myocardial hwvs disease or condition resulting in death) /Medical Due o (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed physician and as the burial-tran resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Tectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 4 Unknown 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 2 **N**O 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 1 🗌 Yes 2 **X**No 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death funeral 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation eral Director: After filled in by the fune Injury 1 Yes 2 No 2 Accident 3 Suicide Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral C

completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year)

10 8h

DHMH 17 Rev 1/2001

11595

State Registrar

FEB 1 0 2012

30. Name and address of person

31. Date filed (Month, Day, Year) -

LAUREN GRAHAM

MD 4940 EASTERN A

32. Registrar's Signature

2. January J. January

MD

who completed cause of death (Item 23a) (Type, Print)

RES-000

2012

FEBRUARY

4940 Eastern Avenue, Baltimore, MD, 21224

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death February 5. 5:20 P M 2012 SANCHAGRIN IHEUDORE 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Washington 102 E. Cemetery Street Funkstown If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) Hours Min Months 1 X M 2 🗆 F Dec 23, 1920 New York 91 10c. City, Town or Location 10d. Inside City Limits 10b. Count Funkstown 1 Yes 2 X No Washington 10f. Zip Code 10g. Citizen of What Country? 21734 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Yes 2 No If Yes, Give Year or Dates. Black, White, etc. White 1 ☐ Yes 2X No Specify: 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Magazine Editor 18. Mother's Name (First, Middle, Maiden Surname) Maud Sampson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 50 E. South Street Frederick, MD 21701 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Final Journey Crematory 02/07/12 Woodbine, MD Going Homess Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 Approximate Interval Between Onset and Death CONGESTIVE HEART Due to (or as a consequence of) YEARS HYPERTENSION Due to (or as a consequence of)

Social Security Number Funeral **Director** 079-09-5861 ms 23a or 28a-f show must be notified at 10a. State Director MD 10e. Street and Numbe Funeral 102 E. Cemetery Street or items Examiner by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 nan "natural", o Medical Exam 3 Widowed 4 X Divorced Completed Je filed with... ⁴al Hygiene. ar than "p Elementary/Secondary (0-12) traumatic event, the and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) Lyndhurst Clinton Sanchagrin 19a. Informant's Name/Relationship (Type, Print) Amanda West/daughter 1 and 2 s of Health item 27 20a. Method of Disposition Page 1 Department of Important: If it any injury or o once. jo 1
Burial 2
Cremation 3
Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Lice 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Ph.sician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury death certificate be executed the attending physician and hed for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE asn 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Year Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ g ☐ Unknown Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, has been sig ge 2 should b 1 ☐ Yes 2 ☐ No 3 X Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law autopsy page performed? this certificate 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospita! 2 No Other: ျှ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: within 24 hours after death.

To the Funeral Director: After 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No M Investigation Accident the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29c. License number 29d. Date signed (Month. Day, Year, 29b. Signature ē 0188320 FEBRUARY 6 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) STEVEN BLASH, MD HAGORSTOWN am 12916 CONAMAR DR SUITE 204

31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar Deneur S. Janes ORIGINAL

DHMH 17 Rev 06-2011

Physician/

Medical

Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Physician/ Prehlad K. Saluja Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death Examiner Regional Hospital Prince George's Laurel Laure 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8 Date of Birth 9. Birthplace (State or Foreign 6 Sex 7. Age (In vrs. last birthday) **Funeral** Days (Month, Day, January 21 Months Hours 1 □ M 2 🙀 F 76 Director 1936 Pakistan 215-21-4982 Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10d Inside City Limits 10a. State 10c. City, Town or Location Funeral Director 1 √ Yes 2 □ No Rochester Hills Michigan 0akland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 1668 Ridgecrest 48306 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🔀 No If Yes, Give Completed by 1 ☐ Never Married 2 🔀 Married Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: Specify: Asian Indian 3 ☐ Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home 10 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Uttam K. Singh Nirmal Singh 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1668 Ridgecrest, Rochester Hills, Michigan, 48306 <u>Jagjit S. Saluja/Husband</u> Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
West Arundel
Crematory 20a. Method of Disposition 20c. Location - City or Town, State Date February 1 Burial 2X Cremation 3 Removal from State 4 Donation 5 Other (Specify) 2012 Odenton, Maryland 22. Name and Address of Facility Donaldson Funeral Home & Crematory, P.A. 1411 Annapolis Road, Odenton, Maryland 21113 21. Signature of Funer ervice Coensee M01386 20 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, a heart failure. List only one cause on each line. Approximate Interval Between OCARDIAL INFARCTION Onset and Death Immediate Cause (Final disease or condition resulting in death) Ph_sician/ Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or linjurathat initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Pregnant at time of death Part II. Other significant donditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records. 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner?
1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 뎯 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA funeral 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 1 □ Yes 2 □ No 28d. Describe how injury occurred 1 Natural 5 \square Pending s after death. Investigation Accident filled in by the Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 20a Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 hor To the Funer completed fil Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check

Registrar DHMH 17 Rev 7/2009

State

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

FEB 1 0 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MITUL DAVE 9055 CheV90lef

32. Registrar's Signature

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 June B. Scheidle February 0 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 717 Maiden Choice Lane, SC 224 Catonsville Baltimore Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛛 F Months Days Hours Min. 3/29/1932 Maryland 79 Director <u> 218-28-3626</u> Usual Residence of Decedent show 10a. State 10b. County be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director "natural", or items 23a or 28a-f s dical Examiner must be notified 1 🗌 Yes 2 🔀 No MD Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 717 Maiden Choice Lane, SC 224 21228 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Was Deceus... Armed Forces? □ Yes 2 🔀 No 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: White Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) t. Page 1 and 2 should be fi trnent of Health and Mental rtant: If item 27 is marked jury or other traumatic ev marked 2 John Cordes Gertrude A. Grahe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Scheidle / Daughter 3000 Taylor Makenzye Ct., Oak Hill, VA 20171 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of H Important: If ite 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) injury or 2/14/2012 MD Veterans Cemetery Ownings Mills, MD 21. Si hall re of Funeral Service Ligensee Hubbard Funeral Home, Inc. 4107 WIlkens Avenue, Baltimore, Maryland 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such shock, or heart failure. List only one cause on each line. Approximate Interval Betwe Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due r as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or linjury or Attending Physician; The law requires that the death certificate be executed the burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of) Physician/Medical P.O. Box 68760 be detached for use as IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Ectopic pregnancy 5 Other (specify) Month Day Year Pregnant at time of death Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Records, 1 ☐ Yes 2 ☑ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Ma. Was an page 2 s rformed 1 🗌 Yes **Division of Vital** funeral director, 25. Was case referred to medical 26. Place of Seath (Check only one) Be examiner? Hospital: Other: 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 🗌 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28c. Injury at work? 1 🗌 Yes 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 24 hours after death. Funeral Director: A 2 No Accident Investigation 6 🗌 Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined Hospital Medical 🖳 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2. only one)

State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, FEB 1 0 20)

MAIDEN ChOIC

TTENDING

32. Registrar's Sig

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MACHIRAN

29d, Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician James Sacker -2012 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner HCR ManorCare Catonsville Baltimore Social Security Number 6. Sex 2 M 2 ☐ F If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 03/13/1928 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 215-24-1218 83 MD Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, If we Misclical Experiment has matthed an ance. MD Baltimore Director 1 Yes 2 No 10e. Street and Number 10g. Citizen of What Country? 2145 Whistler Ave. 21230 USA Funeral 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2XXXIo ģ Specify: Specify: 3XXWidowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Fabrication Elementary/Secondary (0-12) College (1-4or 5+) Sheet Metal Worker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Claude Sacker Josephine Prucha 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
416 Hillview Dr., Apt. 103, Linthicum, MD 21090 Josephine K. Jordan / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)
W. Arundel Crematory 02/09/2012 20c. Location - City or Town, State 1 ☐ Burial 2 A Cremation 3 ☐ Removal from State Odenton, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Serve Lisensee 22 Name and Address of Facility Bailey Funeral Home and Cremation Svc. PA 4023 Annapolis Rd., Halethorpe, MD 21227 Signature of Inlant M01452 23a. Part1. Enter the disease, or complicitions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** om-1-000 /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the aftending physician and Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: yes, outcome of pregnancy
Live birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an cate has page 2 s autopsy perform 2 No 1 □Yes 25. Was case referred to medical examiner? director. Medical Certification: To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certific 00001765 O 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 1/2001

State

Den 22er

Quainoo Mo

3350 WILLENS AUR Balt. MD 2129

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ FEBRUARY P M 2012 9:40 DENNIS TAYLOR Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** MONTGOMERY HOLY CROSS HOSPITAL SILVER SPRING If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours Min oCT. 12 WASHINGTON, DC **Director** ຶ 1967 579-04-5473 1 X M 2 🗆 F 44 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at with the Maryland Director 1 Yes 2 No DC WASHINGTON 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? of Health and Mental Hygiene.
item 27 is marked other than "natural", or items 23a other traumatic event, the Medical Examiner must be Funeral 745 PARK ROAD N.W. 20010 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 X No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2X No Specify: BLACK Specify: Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) ACCOUNTANT PRIVATE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ **JAMES** TAYLOR ALICE PETERS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) KIMBERLY TAYLOR LOGAN/SISTER 745 PARK ROAD N.W. WASHINGTON DC 20010 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date Department of H Important: If ite any injury or ot once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) FT. LINCOLN CEMETERY 2/15/2012 BRENTWOOD, MARYLAND 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME, INC. 21. Signature of Funeral Service Licensee 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 Approximate Interval Between Onset and Death Physician/ Medical resulting in death) Due to (or as a consequence of): Examiner TERMINAL ENCEPHLOPATHY Sequentially list conditions, if any leading to instructions cause. Enter Underlying Exami Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last ding physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Pregnant at time of death been signed by the a should be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by MULTIPLE SCLEROSIS 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autops performed? Yes 2 X No 1 Yes 2 No Yes • Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director. I 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 2 🔀 No 2 1 Tes 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work?
1 \[\text{Yes} 2 \[\text{No} \] injury X Natural 5 Pending ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town. State) Medical 29a. Certifier 🛂 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one)

Registrar DHMH 17 Rev 06-2011

State

29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

30. Name and address of person who completed

FEB

of death (Item 23a) (Type, Print) CHARU MAHESHWARY MD 1500 FOREST GLEN ROAD SILVER SPRING, MARYLAND

Registrar's Signat

29c. License number

D68681

29d. Date signed (Month, Day, Year,

FEBRUARY 9, 2012

20910

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #5 Per FH G925 3/2//2012 JH State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 8:50P M Physician/ February 8, 2012 FRANCIS XAVIER TRACEY Medical 4c. County of Death
Baltimore County 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Baltimore 311 Hopkins Road If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year, 9. Birthplace (State or Foreign 183-22<u>/</u>4070 7. Age (In vrs. last birthday) **Funeral Director** 1 XM 2 □ F Nov 11, 1929 Pennsylvania Yrs 82 Usual Residence of Decedent 28a-f show 10b. County 10d. Inside City Limits iral", or items 23a or 28a-f shor Examiner must be notified at 10a. State 10c. City, Town or Location Director Maryland Baltimore County 1 ☐ Yes 2X No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21212 USA 311 Hopkins Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 Married ģ 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: White "natural", Completed 3 X Widowed 4 Divorced Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) **5+** the Salesman Printing other permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, i Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Helen Alice Bell James Tracey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 4450 Bristol Drive, Chesapeake Beach, MD 20732 Grace T. Ridgeway (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Green Mount Crematory 2/10/2012 Baltimore, Maryland 4 Donation 5 Other (Specify) Signature of Funtral Service Conservor MINTCHELL WILDEFELD FUNERAL HOME INC 6500 York Road, Baltimore, Maryland 21212 Martin D. Lawson Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Pleural -Physician/ Malignancy Months disease or condition resulting in death) Medical Due to (or as a consequence of **Examiner** Sequentially list conditions Examiner Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events that the death certificate be executed the burial-trar Due to (or as a consequence of): resulting in death) Last signed by the attending physician Id be detached for use as the buria Physician/Medical IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Year Day Month 4 ☐ Pregnant at time of death g ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hypertension 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? Was a. autopsy performed? 24a. Was an has certificate 2 No 1 Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA မ this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of 28d. Describe how injury occurred Certificate: within 24 hours after death. To the Funeral Director: After To the Hospital or Attending 1 Natural 5 Pending 1 Yes 2 No filled in by the Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier completely (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certif 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 06-2011

0 8

Baltimore, Maryland 21215-0036

Box 68760

P.O. I

Division of Vital Records,

Rameen J. Molavi, M.D., 10755 Falls Road, Suite 200, Lutherville, MD 21093

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

D54717

12012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

lphonso Edward		ompson, Jr. St	ate of Maryl		partme Certifica			and	Menta	al Hyg		eg. No.	20	12	0380
Physicia		Registrar 1. Decedent's Name (First, Midd	le,Last)						-		. Date of Dea	th	Vana	3.	Time of Death
Andical Examin		ALFONSO	EDWAF	STD.	THOMP	SON	JR.				Month February				2339 hrs
*		4a. Facility Name (if not institutio	n, give street and n	umber)		41	c. City, To		ocation of	Death			County of ince Ge		
J. 37		5005 78th Avenue		17 4 (1	- last birth	dau)	Hyattsv		If Under	24Hre	8. Date of Bir	i			ace (State or
Funeral Director		5. Social Security Number	6. Sex	7. Age (In y	rs. last birth		If Under Months	Days	Hours	Min.			F	oreign N	IARYLAND
Director		220-19-7548	1 M 2 F	23		Yrs.					JUNE	8 19	88	Codrill	97
any	<u> </u>	Usual Residence of Decedent 10a. State 10b. County		10c. 0	City, Town o	r Locatio	n								d. Inside City Limits
B		MD PRINC	E GEORGE	S	GREEN	BELT	•							1	Yes 2 No
Maryland 28a-f show d at once.	Director	10e. Street and Number	E odonoz				10f. Zip C	ode			1	0g. Citize	n of Wha	Country	?
0036 within 72 hours after death with the Maryland piene. ber than "natural", or items 23a or 28s-f sho Medical Examiner must be notified at once.	盲	7076 HANOVER P	ARKWAY					2077	0			US.	A		
with ms 23	la l	11. Marital Status		cedent Ever i	n Ü.S.		Decedent s, specify				cify Yes or No)- 1·	4. Race -		Indian, Black,
or ite	Funeral	1 X Never Married 2 M	1 Yes	2 X N	0			7			,				
s after	4	3 Widowed 4 Div	orced If Yes, Give Ye or Dates:		1) 16a D		Yes 2		specify: on (Give kir	nd of wo	rk done		pecify:B]		strv
5-0036 led within 72 hours after Hygiene. other than "natural";	Completed	Elementary/Secondary (0-12)		(1-4 or 5+)			st of worki								,
thin 7. the	e le	12th				CHE	7					P	RIVA	ΓE	
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than	힑	17. Father's Name (First, Middle	, Last)	-		OHLL		18	3.Mother's	Name (I	First, Middle,	Maiden S	urname)		
2121 uld be fil Mental H marked	å	ALFONSO THOMPS	SON SR.								CURRY			01-1- 7	0.10
D 2,	ှင	19a. Informant's Name/Relations SABRINA CURRY /			19b.	Mailing 176 F	Address IANOV	(Street a ER F	and Numb	er or Ru GREE	ral Route Nur NBELT ,	MARY	LAND	207	7 O
imore, MD Z Pages 1 and 2 shou ment of Health and N rant: Uftem 27 is n or other traumatie	ŀ	20a. Method of Disposition		26	0b. Place of	Disposit	ion (Name				Date		ocation - C		
Baltimore, permit. Pages 1 a Department of He Important: If ite		1 Burial 2 X Cremation		from State	cremato RIVERI			АТОБ	RY	2/11	/2012	RI	VERD	ALE,	1ARYLAND
Baltimo permit. Page. Department o Important:	-	4 Donation 5 Other S	pecify:				me and A						_		HOME, INC.
Depa Depa		13 kyan	Hurts			7/	174 T.	ANDO	VER						AND 20785
Physician	1	23a. Part I. Enter the disease, or failure. List only one cause		caused the de	eath. Do not	enter the	e mode of	dying, s	uch as car	diac or i	respiratory an	rest, shoc	k, or hear	1 7	Approximate Interval Between Onset and
↓Medical £xaminer	71	Immediate Cause (Final disease	Ours had t	Vound of h	Head									-	Death
ZAGIIIIICI		or condition resulting in death)	Due to (or as	a consequen	ce of):										
	<u>ا</u>	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	a consequen	ce of):									\dashv	
	Examiner	cause. Enter Underlying Cause (Disease or Injury that initiated	С.											_	
nsit red		events resulting in death) Last	Due to (or as	a consequen	ce or):										
e executed cian and rial - transit	dical	UNPENDED	MENDED	Item#1	l as n	oted	l,per	me,	g925	3-8	3-12 sm	1			
760, ficate be g physici the buri	Med	IF FEMALE:		, outcome of p									Date of d	elivery	
687 ertifica ding p	lan/I	23b. Was decedent pregnant in the past 12 months?	I LIVE	birth mant at time o	2	=	al death	3	Ectopic	pregnan	су	N	/lonth	Day	Year
Box 68760 e death certificate b the attending physical or for use as the bu	Physician/Me	1 Yes 2 No 9 Un	known 9 Unk		ordeath 5	Oth	er (S <i>pecif</i>	y)				13			
O. B at the da I by the		Part II. Other significant condi-	tions contributing	to death but r	not resulting	in the ur	nderlying o	ause giv	ven in Par	t I.	23e. Did t	obacco u	se contrib	ute to the	cause of death?
, P.O.	d b										1 Ye	s 2 🗸	No 3	Probab	y 4 Unknown
ords, w requis	lete										24a. Was auto				sy findings available pletion of cause of
eco he law tte has	Completed											ormed? 2 No	de 1	ath? ✔ Yes	2 No
Vital Rec ystelan: The his certificate director, page	Be C	25. Was case referred to medica					26		of Death (0						
Vita	P	examiner? 1 Yes 2 No	Hospital: 1	Inpatient 2		tpatient					Home 5				cene
ling Ph	1	27. Manner of Death 1 Natural 5 Room	FOMRI	e of Injury th, Day,Year) D:	28b. T FOUI	ime of In VD:	jury 28		at Work?	I.S	28d. Describe Subject sho	now injur ot	у оссите	1	
SiOr Attend death ctor:	äŧ		estigation Feb 6,		2330	hrs	factory			1 2	28f Location /	Street an	d Number	or Rural	Route Number, City
Division of Vital Records, talor Attending Physician: The law requirers after death. al Director: After this certificate has been sited in by the funeral director, page 2 should be	Certification	doto	la not be	Docal S		m, saee	i, laciory, i	Jillice Du	iliding, oto		or Town, 005 78th Av	State)			, , , , , , , , , , , , , , , , , , , ,
Lospital of hours a wateral like filled		4 V Homicide 29a, Certifier 1 Certifying P	hysician: To the b			th occurr	ed at the t	ime, dat	e and plac	-					
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the built	Medical	(Check only one) 2 Medical Exa	aminer: On the basi and manner	s of examinati	on and/or in	vestigati	on, in my	opinion,	death occ	urred at	the time, date	and plac	e, and du	e to the c	ause(s)
F . F . S	Me	29b. Signature and title of certification			_		29c.	License	number						Day, Year)
		16t	Inon.		000	لحريد		O.C.N	1.E.			Febr	uary 7,	2012	
		30. Name and address of person					200.121	D = IL.	Ct	- A D	altino a ==	ID 2422	2		
		Patricia Aronica-Polla		tant Medic				Baitim	ore Stre	et, Ba	ailimore, N	- Z 1 Z Z			
St Regis	ate	31. Date filed (Month, Day, Year)	012	Registrar's Sig	i ature	arka									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Villiam Anthony	y Tabor State of Maryland / Department of Health and Mental Hygiene 1- For State Registrar 1- For State Registrar 1- For State Registrar 1- For State Registrar												8 N			
Physicia	an/	Decedent's Name (Fire 1. Decedent's Name (Fire 1. Decedent)	rst, Middle,L	ast)						2	Date of Dea	ath	Year	3.	Time of Death	5
Medical Exami	ner	WILLIAM		NTHON	y -	TABO	SR.				January 5				2258 hrs	
		4a. Facility Name (if not 6007 Euclid Str		give street and	number)		4	b. City, Town, o	or Location	of Death			ounty of D			
Funeral		5. Social Security Numb		Sex	7. Age (In	yrs. last b	irthday)	If Under 1 Ye	ar If Und	er 24Hrs.	8. Date of B				ace (State or	
Director		229.27.94	5/2 1	X M 2 F	3	7	Yrs.	Months Da	ys Hour	s Min.	azla	110-	1/1 F	oreign Countr	WEW YE	20
		Usual Residence of Dec	edent								02/0	8 119	19 1		MCM 46	KK
w any		10a. S tate 10b.	County	_	10c.	City, Tow	n or Locati	on							d. Inside City I	
Maryland 28a-f show 1 at once.	ţo	MARYLAND PR	INCE G	PRORGE'	s C	HEVE	RLY	L 101 71 0 1							Yes 2	_ No
ith the Maryland 23a or 28a-f sho notified at once	Director	10e. Street and Number						10f. Zip Code				-	n of What			
vith th		11. Marital Status	LID 5		ecedent Ever	r in U.S	T13 Was	20783 s Decedent of F		igin? (Spec	ify Yes or N	UNITE	D S		ES Indian, Black,	
eath v item	Funeral	1 X Never Married	2 Marrio	A	Forces?		If Ye	es, specify Cuba	an, Mexicar	n, Puerto Ri	can, etc.)		White, e		maian, brack,	
after d	by Fi	3 Widowed 4	Divorc	ed If Yes, Give Y		NO	1	Yes 2 X N	lo specify	:		S	pecify; W	HIT	Ξ	
5-1036 led within 72 hours after death with the Maryland thygiene. other than "natural", or items 23a or 28a-f sh the Medical Examiner must be notified at once	ed k	15. Decedent's Educat		only highest g		ed) 16a		t's Usual Occup ost of working lit				16b. Kir	d of Busine	ess/Indu	stry	
2 - 2	plet	Elementary/Secondar	y (0-12)	-	(1-4 or 5+)		v) Co		_		,	naci		4		
15-0036 filed within 72 Hygiene. d other than '	Completed	17. Fatner's Name (First	, Middle, La	<u>3</u>			140	SISTAN		r's Name (F	irst, Middle,	Maiden St	OIC (A			
21215-9036 suld be filed within 7 Mental Hygiene. marked other than	Be (WILLIAM	TABOR	2					MAR	MANA.	E	HOUL	HAN)		
ID 21 should and Me 7 is man	٢	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zi													•	
re, MD s 1 and 2 sho of Health and If item 27 is	}	20a, Method of Dispositi	TAB	OR - FR	THER	20h Place	3448	FLINT T	TUERN	PLACE	e, WO	OPBRID	GE, V	A Z	219Z	
		1 Burial 2 C		Removal			atory or oth		errietery,	L , '	4	200. 20	cation - Cit	y or row	ni, State	
or marginal		4 Donation 5 21. Signature of Special			í	FAIRFA	K MEM	ORIAL PR	ARK PROVIDE	01 12	2012	FAI	ZFAY,	VA	_	
Balt permit. Departs Import		21. Signature of Land		erisee			Hán 32	ame and Addre	"7221 ansk	Gray	bûrn i ∨d.,	Wood	Glen	BUT	rie, MD	210
Physician		23a. Part I. Enter the dis			caused the	death. Do				4					pproximate In	
/Medical Examiner		Immediate Cause (Final	disease	_{a.} Amphetai	mine Intox	cication								,	Death	anu
		or condition resulting in	death)	Due to (or as	a conseque	nce of):										
	er	Sequentially list condition if any, leading to immed	iate	Due to (or as	a conseque	nce of):										
	Examiner	cause. Enter Underlying (Disease or injury that in	nitiated	C.												
ansit de de		events resulting in death		Due to (or as	a conseque	nce or):										
be executed irician and urial - transit	dical	UNPENDED			#22pa	rFH C	2024 2	2/10/201	12 1.70							
	Mec	IF FEMALE:		23c. If yes	s, outcome of	pregnanc	y	2/10/20	LZ,W3			23d. I	Date of del	ivery		
Box 68760 te death certificate by the attending physical ted for use as the br	Physician/Me	23b. Was decedent pregr past 12 months?	nant in the		birth gnant at time	of		al death 3	Ectopi	ic pregnanc	у	М	onth	Day	Year	
30X death he atter	ysic	1 Yes 2 No 9	Unknow	Hea		OI .	5 Oth	ner (Specify)								
that the d	- 1	Part II. Other significan	t condition	s contributing	to death but	not result	ing in the u	nderlying cause	given in P	art I.	23e. Did t	obacco us	e contribut	e to the	cause of death	1?
Vital Records, P.O. hysician: The law requires that the this certificate has been signed by all director, page 2 should be detach	Completed by										1 Ye	s 2 🗸 I	No 3	Probabl	4 Unkn	own
w request special	olete										24a. Was auto	psy			y findings ava eletion of caus	
Reco	L L										perfo 1 ✓ Yes	rmed?	deat 1 ✓	h? Yes	2 N	lo
tal F	Bec	25. Was case referred to examiner?	medical	[1 He]				26.Plac		(Check on	y one)					
Physic r this all dire	P	1 ✓ Yes 2	No	Hospital: 1	Inpatient		Outpatient		Other ₄		lome 5		e 6 🗸 C	ther: Sc	ene	
Division of Vital Records, P.O. Ital or Attending Physician: The law requires that the rs after death. To Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach	on:	27. Manner of Death 1 Natural 5	Pending	E OMRI	te of Injury hth, Day,Year) D:		o. Time of In OUND:		ury at Worl	_ lei	Bd. Describe Ibject inje	now injury	occurred escribed	amph	etamine	
IVISIOR Or Attendafter death Director:	icati	2 Accident	Investiga	Jan 5,			51 hrs	t, factory, office			of Location (Street and	Number o	r Rural F	Route Number	City
Divi spital or s tours after seral Dir	ertification:	3 Suicide 6 4 Homicide	✓ Could no determin	ot be	y) Reside		,	, , ,	.		or Town, 07 Euclid	State)			todio ridiribor	Only
Hosp 24 hou Func	ပ	20a Codifier	ifying Physi				eath occurr	red at the time,	date and pl	ace, and du	e to the cau	se(s) and	manner as	stated.		
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the b	Medical			er:On the basi and manner		tion and/or	r investigati	on, in my opinio	on, death o	ccurred at the	ne time, date	and place	e, and due	to the ca	use(s)	
	Σ	29b. Signature and title of	of certifier	11/20					nse number				te signed		Day, Year)	
		Myh.	Beau	4/11/2	5			0.0	.M.E.			Janua	ary 6, 20	112		
りり		 Name and address of Melissa Brassel 					,	Baltimore	Street. F	Baltimore	MD 212	23				
St	ate	31. Date filed (Month, Da			Registrar's Si						, = =		<u> </u>			
Regist	rar	FEB 1 0 20	12 /		1. 1	back	6									
			. /	_	1 /2											

DHMH 17 Rev 1/2001 OCME 2006

OCME

ORIGINAL

amend #17 Perstate 692 Mary at 2013 art thent of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death HOMAS Physician/ TATE 02 06 2012 9:25p Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A Baltimore Future Care Homewood If Under 1 Year I If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday, **Funeral** Months Days Hours 213-36-5490 1 🗙 M 2 🗆 F **Director** Maryland 02/15/1940 71 Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10c. City. Town or Location must be notified at Director 1 XYes 2 No MD N/A Baltimore 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral items 23a 2700 Charles St. 21218 U.S.A death v 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status 12. Was Decedent Ever in U.S. Examiner Armed Forces?

1 Yes 2 No
11 Yes, Give Black, White, etc. ō ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 filed within 72 hours after 1 ☐ Yes 2 🙀 No Specify: Specify: Black "natural" Completed 3 ₩ Widowed 4 □ Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working of Health and Mental Hygiene. life. DO NOT use retired) ementary/Secondary (0-12) College (1-4 or 5+) 11th Grade Super Market Porter other traumatic event. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Esa Earl Lucas Page 1 and 2 should be Mabel Conner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Earlean Hairston(Sister) 4303 Kathland Ave., Baltimore, MD21207 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date o = 0 1 Burial 2 Cremation 3 Removal from State Department of Important: If any injury or on-site Crematory 02/09/12 Baltimore, MD 4 Donation 5 Other (Specify) 22 Name and Address of Facility Joseph H. Brown Jr. 2140 N. Fulton Ave., 21. Signature of Fulleral Service Licenses Funeral Home PA Baltimore, MD21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause n each line Onset and Death Immediate Cause (Final MOXIC ence Physician/ disease or conditi-resulting in death) Medical Due o (or as a consequence of) Examiner Carollac Secuentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) VA Exami use as the burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Year Pregnant at time of death ed by the a detached f 9 Unknown s been signed by the should be detack Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
 1 □ Yes 2 □ No 24a. Was an page 2 s Division of Vital funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be 1 🗌 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Medical Certificate: 28c. Injury at 28d. Describe how injury occurred : After injury 1 Natural 5 Pending 1 Yes 2 No s after death Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, ☐ Homicide determined 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29c. License number 29d. Date sjigned (Month, Day, Year) MD 2012 Itmore MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. EVIAW STR. 308 MITSANI MD 2120 31. Date filed (Mginth, Day, State Registrar DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEN DITEM#20b, perFH, G924, 2/17/2012, WS
State of Maryland / Department of Health and Mental Hygiene 20 | 2 03803 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 2012 Gloria White February 1915P Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Silver Spring Montgomery Holy Cross Hospital Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 7. Age (In vrs. last birthday. **Funeral** Days Hours (Month, Day, Year) 578-66-4507 64 **Director** 1 □ M 2 🕅 F 12/11/1947 Washington, DC 28a-f shov items 23a or 28a-f sho her must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Director 1 X Yes 2 No Bethesda MD Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20816 5401 West Bard Avenue #105 USA death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Armed Forces?

1 Yes 2X No Black, White, etc. ō 1 Never Married 2 Married ρ Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: Specify: "natural", Completed 3 Widowed 4 Divorced Black the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) of Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) BS Correctional Officer Federal Government other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Beatrice Morrow Waddell Robertson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5401 West Brad Avenue #105;Bethesda, MD 20816 Charlie White/ Husband Lepartment of H Important: If iten any injury or otho 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State Arlington Vet. Cem. 2/22/2012 Arlington, Virginia 4 Donation 5 Other (Specify) 21. Sign proof Funeral Service Incensee 22. Name and Address of FaciliFreeman Funeral Services 20748 4594 Beech Road; Temple Hills, MD Part 1 Anter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock of heart failure. List only one cause on each line. Approximate one cause on each line. Interval Between Immediate Cause (Final Onset and Death espirator Ph sician/ disease or condition resulting in death) Medical Due to (or as consequence of): Examiner 3K Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and burial-trar that initiated events Due to (or as a consequence of): resulting in death) Last signed by the attending physician d be detached for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 for use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Pregnant at time of death 2 No 1 Yes 2 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown completely filled in by the funeral director, page 2 should i 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed Yes 2. No 25. Was case referred to medical examiner?

1 Yes 2 No 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural iniury 5 Pending work?
1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 within 2 To the F only one 29b. Signature ٥ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Lauson 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB 1 0 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 6:06 P M Wilcox Carolyn Sue February 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 2509 Londonderry Road Baltimore Timonium Age (In yrs. last birthday) Social Security Numbe If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** (Month, Day, Year) v 5, 1934 1 🗆 M 2 🗶 F Davs Hours Min **Director** 027-30-8789 Vermont 77 Nov Usual Residence of Decedent 28a-f show or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location with the Maryland 10d. Inside City Limits Director 1 Tes 2 X No Maryland Baltimore Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21093 2509 Londonderry Road USA Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene. sant: If item 27 is marked other than "natural", or items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. If Yes Give 3 Widowed 4 Divorced Specify: Completed Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Registered Nurse Healthcare Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Nelson Milo Smith Adelaide Clark Gertrude 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bruce N. Wilcox/Husband 2509 Londonderry Road, Timonium, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of F
Important: If ite
any injury or ott 2/10/2012 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Dulaney Valley Memorial Gardens Timonium, Maryland 22. Name and Address of Facility
Lemmon Funeral Home of Dulaney Valley Inc.
Lemmon Funeral Home of Dulaney Waryland 21093 Sign of Funeral Service Licen Bryan W. Clary Padonia Road, Timonium, Maryland Part 1. Enter the dis shock, or heart faile ease, or complications that ca ire. List only one cause on ead leath. Do not enter the mode of dying, such as cardiac or respiratory arrest, sed the Approximate Interval Between shock, of heart fail Immediate Chuse (Final disease or condition Onset and Death Armystopic Lateral Scheross Ph_{sician} Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause: Enter Underlying Physician/Medical Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (wisease or impury that initiated events the burial-tran Due to (or as a consequence of): resulting in death) Last Box 68760 attending p for use as t IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 - Fetal death 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Pregnant at time of death signed by the a d be detached f 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 🗹 No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has autopsy performed? death? certificate 2 No within 24 hours after death.

To the Funeral Director: After this certific: completed filled in by the funeral director, I 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) D 0026575 February 6, 2012 30. Name and address overson who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 7/2009

State

David J. Hartig,

FEB 1 0 2012

31. Date filed (Month, Day, Year)

MD

10155 York Road, Suite 200, Cockeysville, MD 21030

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 () | 2 Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ DOROTHY GEORGETTA COGGINS WEIDNER 6:15 AM February Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore N/AKESWICK MULTI-CARE CENTER 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs 8. Date of Birth 5. Social Security Number 6. Sex . Age (In yrs. last birthday) **Funeral** Year 906 $\operatorname{Jul}^{Month}2^{Day}$ Months Days Hours 1 M 2 X F Maryland 105 Director 218-12-4907 Usual Residence of Decedent show or 28a-f shov notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland Director 1 X Yes 2 No N/ABaltimore Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ò er than "natural", or items 23a of the Medical Examiner must be Funeral 700 West 40th Street 21211 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. by 1 Never Married 2 Married 1 Yes If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White Completed 3 - Widowed 4 X Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene Important: If item 27 is marked other the any injury or other traumatic event, the once. Blue Print Reader Manufacturing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Lawrence Stella Yeager Coggins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Terry Sullivan (Guardian) 10 North Calvert St., Suite 200, Balto., MD 21202 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State Parkwood Cemetery 2/9/2012 Parkville, Maryland 4 Donation 5 Other (Specify) Martin D. Lawson Name and Address of Facility MITCHELL-WIEDEFELD FUNERAL HOME, INC. 6500 York Road, Baltimore, Maryland 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph, i ian/ 40 TUNIVE - Michelian disease or condition Failure Medical resulting in death) Due to (or as a consequence of) **Examiner** DEWENTIG Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed ending physician and use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE IF FEMALE.

23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 mor ő Month Day Year Pregnant at time of death 2 No g 🗌 Unknown 9 I Inknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? has autopsy 1 Yes 2 N 1 ☐ Yes 2 ☐ No this certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other 2 No 1 Inpatient 2 ER/Outpatient 3 I DOA ျာ 1 🗌 Yes 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: injury work?
1 ☐ Yes 2 ☐ No 1 Natural 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number 2/6/12 D0054057 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) V3 EST YOU ST But WO NO 702

DHMH 17 Rev 7/2009

State Registrar fonth, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 U 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ RACEIWI Month Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel 1044 Lily Way Odenton 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7 Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days (Month, Day, Year) 182-14-6125 **Director** 1 🗆 M 2 🗘 90 January 2, 1922 Pennsylvania Usual Residence of Dece 28a-f shov at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director notified PA New Castle 1 Yes 2 No Lawrence 10e. Street and Number 0 10f. Zip Code 10g. Citizen of What Country? Medical Examiner must be Funeral items 23a United States 219 Winter Road, Unit 1B 16101 within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Black, White, etc. ō ģ 1 Never Married 2 Married 2 X No Yes Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify Specify: White "natural", Completed 3 X Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the 12 Homemaker Own Home Be be filed \ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F permit. Page 1 and 2 should be.
Department of Health and Mental Important: If item 27 is many injury or other မ Edward Reynolds Florence Moore 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2933 Wandering Way, Columbus, Indiana 47201 Linda Long/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 10 February Castle View Gardens 4 Donation 5 Other (Specify) 2012 New Castle, Pennsylvania 21. Signature of Funeral Service Lisensee Donaldson Funeral Home & Crematory, P.A. 1411 Annapolis Road, Odenton, Maryland 21113 Will Expour M00672 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between ND Immediate Cause (Final Physician STAGE disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions Examine Due to for as a consequence of if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the as IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy5 Other (specify) in the past 12 month Month Day Year Pregnant at time of death detached the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 Yes 2 No 3 Probably 4 thinknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 2 🗌 No 1 Yes or Attending Physician: filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) DAUGHTERS Other: 4 Nursing Home 5 Residence 1 Yes 2 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 6 Other (Specif within 24 hours after death.

To the Funeral Director, After this tome 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Defical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated
3 Deficial Examiner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifler 29d. Date signed (Month, Day, Year) 2012 0 30. Name and address of person ed eause of death (Item 23a) (Type, Print) ANNAPOLIS, M.D. 21401 FNEVIEVE 10 EFENSE 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 06-2011

Registrar

FEB 1 0 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Date of Death 3. Time of Death Physician/ 2012 WILLI 352 Medical on give street and number 4c. County of Death **Examiner** Kandallstown Battimore Hospice 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral Director** 1 🗹 M 2 🗆 F 80 28a-f show 10c. City, Town or Location or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 No timore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Yes, specify Cuban Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 Mo Specify: 3 Widowed 4 Divorced Completed Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working 2 should be filed within 7 th and Mental Hygiene. 27 is marked other than Elementary Secondary (0-12) College (1-4 or 5+) VOCKER Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, Be illiams ٩ Daughter Baltimore, Method of Disposition . Place of Disposition Burial 2 Cremation 3 Removal from State 3-12 4 ☐ Donation 5 ☐ Other (Specify) 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or hear riailure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician disease or condition M Medical resulting in death) to (or as a consequence of) Examiner Sequentially list conditions, Examine Director for as a consequence of: cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician I for use as the buria Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year Pregnant at time of death signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records. 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an this certificate has ral director, page 2 autopsy perform Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be 200 examiner? Other: 4 Nursing Home 5 Residence 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28b. Time of hin 24 hours after death.

the Funeral Director: After in a project of filled in by the funeral policies. 5 Pending 1 Natural Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely (Check 3 🗌 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie

State Registrar

DHMH 17 Rev 06-2011

(Type, Print)

completed cause of death (Item 23a)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 7 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ $J_{\text{anuary }}^{\text{Month}}$ 2012 10:20AMM Elizabeth Pauline Atkins Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death The Annapolitan Annapolis Anne Arundel 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** Hours (Month, Day, Year) Director 578-42-0021 1 🗆 M 2 🗶 F 8/19/1914 Virginia or 28a-f show 10b. County the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland 1 Yes 2 X No Anne Arundel Edgewater 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 3236 Rolling Road 21037 USA 11 Marital Status 12 Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?

1 Yes 2 X No Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: White "natural", 3 X Widowed 4 Divorced Specify Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry should be filed within 72 h n and Mental Hygiene. 7 is marked other than "n (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Se 12th //Secondary (0-12) College (1-4 or 5+) Homemaker Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ William David Mifka Helen Benesck 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) If item 27 3236 Rolling Road, Edgewater, MD 21037 Elizabeth A. Curro/ Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State injury or Department Important: I 1/28/12 Lakemont Cemetery Davidsonville, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility George P. Kalas Funeral Home 21. Signature of Papera Service Censee 2973 Solomons Island Road, Edgewater, Md. 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ ANLLE ATLC CA Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) that the death certificate be executed burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: nse s 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for L in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day Year 1 ☐ Yes 2 € 9 ☐ Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The performed? 2 HNo 1 Yes Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b Time of 28c. Injury at work? 28d. Describe how injury occurred After 1 Matural 5 \square Pending 1 Yes 2 No 2 Accident Investigation within 24 hours after deatl To the Funeral Director: filled in by the 6 Could not be 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifie 29c. License numbe 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 06-2011

State

legd

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32.

31. Date filed (Month, Day, Year)

JAN 26 2012

030718

01-23-7012

				se Type or I	Print in BI Maryland								_	ible.	
		•	1 - State Registrar		.,, ,, ,, ,,,,,,		tificate d					Reg. N	0.0	12	03809
	Physicia	m/	1. Decedent's Name (First, Middle,		r						2. Date of De _Month	ath		Vear	3. Time of Death
Apr. in	Medic	cal	George G.	Ardell II							Januar		3,20		1:10 A M
	Examir	ner	4a. Facility Name (if not institution, Shady Grove Adv	entist Hos	spital			kv1	11e				c. County Mont	gomer	
	Funeral Director		5. Social Security Number 233-08-9904 Usual Residence of Decedent	6. Sex 1 🕅 M 2 □ F	7. Age (In yrs. last 50	birthday) Yrs.	If Under 1 Y Months Da		If Under 2 Hours	Min.	8. Date of Bir (Month, Da April	ay, Year)	961	Coun	olace (State or Foreign try) Virginia
	/land f shov ed at	tor	10a. State 10b. County		10c. City, To	own or Lo	cation							1	0d. Inside City Limits
	e Mary r 28a- notifie	Direc	Maryland Montg 10e. Street and Number	omery	Ger	manto									1 🗆 Yes 2 🔀 No
	vith th	ral	20246 Red Bucke	ve Court			10f. Zip Co	_{ае} 2087	76			-		What Coun Stat	
21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ed by Funeral Director	11. Marital Status 1 Never Married 2 Marri 3 Widowed 4 Divorced	12. Was Deced		1	Vas Decedent Yes, specify (of Hispa Cuban, I	anic Orig Mexican	gin? (Speci , Puerto Ri	ify Yes or No- ican, etc.)		14. Rac	e - Americ ck, White, e	an Indian, etc.
2-0	2 hour	plet	15. Deceden (Specify only highes		1	(Give I	ent's Usual Od	one duri	on rina most	of working	7	16b.	Kind of Bu	usiness/Ind	dustry
121	thin 7 ene. • than the Me	Completed	Elementary/Secondary (0-12)	College (1-4	or 5+)	life. Do	NOT use reti inical	red)			,	N	IASA		
d 2	lled w Hygir other vent, t	Be	17. Father's Name (First, Middle, La					18	8. Mothe	er's Name (First, Middle,	. Maider	Surname	e)	
ylar	d be f Menta arked atic ev	입	George Ardell						E1	izabe	eth Sir	non			
, Maryland	nd 2 shoul saith and I n 27 is m er traums	S	19a. Informant's Name/Relationshi				g Address (Str					-			
Baltimore,	Page 1 ar nent of He ant: If iten ary or oth		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 4 ☐ Donation 5 ☐ Other (Sp	3 [XRemoval from S	state cem	etery, cren	sition (Name on atory or other tan Cr	place)		Jan 2012	27,	ı		City or To	
Balt	permit. Departr Import. any inji		21. Signature of Euneral Service Li		(M01117)		Name and A								20877
and the second	Pliy i ian Medical Examiner	0 %	23a. Part 1. Enter the disease, or o shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death)	aa	used the death. En h line. Your Correct ras a consequence	bral	r the mode of		4		respiratory ar	rest,			Approximate Interval Between Onset and Death
90	te be executed lysician and he burial-transit		if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	r as a consequend										
Box 68760	that the death certificate be ex red by the attending physician e detached for use as the buria	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live Bi	ome of pregnancy irth 2 Fetal de ant at time of deaf wn	eath 3 🗌	Ectopic preg						23d. Dat Mo	te of delive	ery Day Year
	S DO		Part II. Other significant condition	ns contributing to dea	ath but not resulting	ng in the u	nderlying caus	e given	n in Part I.						e cause of death?
Records,	The law require cate has been si page 2 should I	Completed by									24a. Was auto perfo 1 □ Yes	psy ormed?	t c	Were autoporior to condeath?	psy findings available appletion of cause of
	ë ≝ 5	Be (25. Was case referred to medical examiner?	Heavitale			2		e of Deatl	h (Check o	-		101	10	
of Vita	this aldi	၉	1 ☐ Yes 2 ☒️No 27. Manner of Death	Hospital: 1 🔀 In	patient 2 ER	/Outpatien					e 5 🗆 Resi				
07	iding I th. After a funer	cate	1 Matural 5 ☐ Pending 2 ☐ Accident Investiga	(Month,	, Day, Year)	injury	,	njury at work? 1 □ Yes	s 2 🗆	- 1	ld. Describe h	now inju	ry occurre	ed	
Division	or Attencation after death Director: A in by the	Certificate:	3 Suicide 6 Could n 4 Homicide determin	ot be 28e. Place of	f Injury - At home g, etc. <i>(Specify)</i>	, farm, stre					3f. Location (S City or Tov			er or Rural	Route Number,
1-5	Hospital or 24 hours afte Funeral Directely filled in	Medical	(Check 2 Medical Ex	hysician: To the bes aminer: On the basis	of examination an	nd/or invest	gation, in my o	pinion, e	death occ	curred at th	ne tirne, date a	and plac	e, and due	to the cau	se(s) and manner stated
	To the Hosp within 24 hor To the Fune	Σ	29b. Signature and title of certifier	Nurse Practitioner: 1	is the best of my h	munnudge:	29c. Lic			s and place	e, and due to t			Month, E	
			Dutos	do.	M.D.		DO	069	5509	5					
			30. Name and address of person w	ho completed cause	of death (Item 23	a) (Type, P	rint) enter	Dr	ive.	Pou	Ku/(12,	140	ary lo	ind:	20850
	Star Registra	LE .	31. Date filed (Month, Day, Year) JAN 2 6 20	12 2. Reg	gistrar's Signature	par	J.			,			,		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 5:00a M Catherine D. Anastasi 2012 Januaru Medical 4a. Facility Name (if not Institution, give street and number, 4c. County of Death **Examiner** 4b. City, Town, or Location of Death Montgomery Manor Care Nursing Home of Bethesda Bethesda 8. Date of Birth Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs 7. Age (In vrs. last birthday) **Funeral** Months Hours Min 577-50-9374 Director 75 1 🗆 M 2 🗓 F July 27.1936 Washington, DC Usual Residence of Deceder 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location at Director must be notified 1 Yes 2 X No Maryland Montgomery Boyds 9 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 14308 Autumn Crest Road 20841 U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 0 þ 1 X Never Married 2 Married Maryland 21215-0036 1 Yes 2X No Specify "natural", Specify 3 Widowed 4 Divorced Completed White Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the Government Contractor Secretaru Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F is marked or ည Angelina DeLeo Rosario Anastasi traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) e 1 and 2 s of Health If item 27 14308 Autumn Crest Road, Boyds, Maryland 20841 Augustine J. Anastasi - Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Department of Important; If any injury or Ft. Lincoln Cem. 01/30/2012 | Brentwood, Maryland 4 □ Donation 5 🕱 Other (Specify) Entombment 22. Name and Address of Facility Hines-Rinaldi Funeral Home. Inc. 232 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Phylician Cardiac Arrest disease or condition resulting in death) Medical Examiner Atherosclerotic Heart Disease Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Diabetes that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Physician/Medical Hypertension Division of Vital Records, P.O. Box 68760 the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Sacral Decubitis 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an Anemia has autopsy performed? Yes 2 🛣 N Colitis 2 No 1 Yes Hospital or Attending Physician; 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 🕅 Nursing Home 5 🗆 Residence 6 🗆 Other (Specify) 2 🗓 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA ည 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at A hours after dec.

**ral Director: After Triangle of the form of 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Medical 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 To the F Certifying Wurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

State Registrar

29b. Signature and title of certifier

Ajay Reddy, 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

JAN 2 6 2012

29c. License number

D53691

3200 Tower Oaks Blud., Suite 110, Rockville, Maryland 20852

29d. Date signed (Month. Day, Year) January 25, 2012

DHMH 17 Rev 1/2001

State

Registrar

Ahmed Heshmat, M.D.,
31. Date filed (Month, Day, Year)

JAN 26 2012

7133 Mill Run Drive, Derwood, MD 20855

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 31570 Jackson Athev Robert 0 Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** 4c, County of Death PICE Salisburu WICOMIC If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday, Hours Min. **Director** 36-5964 1 XM 2 - F 86 Usual Residence of Dece 03 | 07 | 1925 Washington, D.C 28a-f show 10b. County 10a. State 10c. City, Town or Location notified at 10d. Inside City Limits Director 1 X Yes 2 No Salisbury Maryland Wicomico ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? er than "natural", or items 23a on the Medical Examiner must be Funeral 1034 East Schumaker Manor Drive 21804 USA filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married 1 ★ Yes 2 No If Yes, Give Year or Dates. þ Maryland 21215-0036 Army 1 ☐ Yes 2 X No Specify: Specify: White 3 Divorced 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) $\frac{\text{Elementary/Secondary (0-12)}}{12}$ College (1-4 or 5+) 5+ DuPont Chemist and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) P and 2 should be Health and Menta 27 is marked er traumatic e Blanche Golden Samuel Jackson Athey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) June Athey|wife 1034 E. Schumaker Manor Drive, Salisbury, MD 21804 Important: If item 2 any injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State ŏ cemetery, crematory or other place) 1 🗆 Burial 2 🛣 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Salisbury Crematory 01 24 2012 Salisbury, Maryland 21. Sign cure of Funeral Service Licenses Holloway Funeral Home P.A. |501 Snow Hill Rd., Salisbury, Maryland 21804 >CFSP Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Mal Brain Physician/ disease or condition Medical resulting in death) as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or injury that initiated events the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): resulting in death) Last the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Pregnant at time of death 2 🗆 No. 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably Unknown plnous Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy death? Director: After this certificate 1 Yes No 1 Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: Certificate: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) Hospica Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at He 28d. Describe how injury occurred Natural 5 Pending injury work? 2 🗌 No filled in by the Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one re and title of certifier 29b. Signat 29d. Date signed (Month, Day, Year) 1/21/12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) YOGESH VOHRA 910 EASTERN SHORE D DR, SACISBUTY MD 21804 31. Date filed (Month, Day, 32 Registrar's Signature State

Registrar
DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 20 1 2 1:00 P M January Charlotte C. Adkins Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Wicomico Salisbury Wicomico Nursing Home If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Social Security Number 7. Age (In yrs. last birthday) Min. Director 1 M 2 X 146-01-8904 94 01 25 1917 NJ ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 □ No MD Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 105 Times Square 21801 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🎛 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 1 Never Married 2 Married 1 ☐ Yes If Yes, Give þ 1 ☐ Yes 2 🎖 No Specify: than "natural", 3 XWidowed 4 ☐ Divorced Specify: White Completed Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natu any injury or other traumatic event, the Medical and injury or other traumatic event, the Medical. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Bookkeeper Lumber Company 7. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Cornell Emma Sheppard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Francis Adkins | Son 2615 E. Riding Dr., Wilmington De, 19808 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 01 25 2012 Parsonsburg, MD 4 ☐ Donation 5 ☐ Other (Specify) Forest Grove Cem. 1. Signature of Funeral Service Licensee 22. Name and Address of Facility Holloway Funeral Home P.A. 501 Snow Hill Rd., Salisbury, MD, 21804 homoson 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examir the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 month Day Month Year Pregnant at time of death signed by the at d be detached for Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performe Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 100 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) To the Funeral Director: After this completely filled in by the funeral di 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Injury at 28d. Describe how injury occurred Certificate: ✓ Natural 5 Pending work? Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signatur License number 29d. Date signed (Month, Day, Year) 12 R who completed cause of death (Item 23a) (Type, Print)

Registrar

31. Date filed (Month, Day, Year)

5

Francis M Barnes

Control Cont				Registrar			(ertific	ate of	Death			R	eg. No.			
St. Scaling kase of an installation, good arrows and numbers St. Scaling kase of the installation of power and numbers	Ph	ysici	an/	Decedent's Name (First, Midd	le,Last))									Voc		
St. Scaling kase of an installation, good arrows and numbers St. Scaling kase of the installation of power and numbers	Medical E	xami	ner	Francis Mich	nae1	Baı	rnes						January 2	8, 20°	12		1143 hrs
State Control									4	b. City, Town, o	r Location o					f Death	
Second Security Number 1 km 2 km 1 km 2 km 1 km 2 km 1 km 2 km 1 km 2 k				Leonardtown Wharf						Leonardtov	wn			6	Jucon A	nne's	Ct Varrela
The control of the co	F			5 Social Security Number	6 50	-	7 Age (In)	re last hirt	hday)	If I Inder 1 Vo	ar I f Linde	ar 24Hre Is	R Date of Bir	th (MM/	/DDWWY	9 Birt	
20				5. Social Security Number			7. Age (III y	is. last bill	ilday)				o. Date of Bil	a (((I V II V I V	00/1111)	Foreigi	n
Qualification of Deceloral Tills State State State Tills State	Dire	SCIOL		216-70-7536	1 X	M 2 F		53	Yrs.		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		10/10	/195	58	Mar	intry) CV I and
Nary Land St. Mary's Hollywood 10. Epicode 100. Colore 100. Co													107.10				
		an y		10a. State 10b. County			10c.	City, Town	or Locati	on							10d. Inside City Limits
1 1 1 1 1 1 1 1 1 1	-	¥ 5		W 1 1 0 W													1 Yes 2 X No
1 1 1 1 1 1 1 1 1 1	/lano	-f.sh	5		iry'	S	Ho	LTywo	od								
Two. specify Clean, Mexica, Puerts Refer at Two. Specify Clean,	Мал	d at	ည	10e. Street and Number						10r. Zip Code			1	Ug. Citi	zen of vvn	at Coun	itry?
Two. specify Clean, Mexica, Puerts Refer at Two. Specify Clean,	the	tific	Ö	23955 Hollywoo	od R	load				20636				Uni	tod S	Stat	0.5
Two part of the	with	s 23	2		Ť		cedent Ever	n U.S.		Decedent of H			ify Yes or No				
Accounting Technician Civil Service 3	ath		2	1 X Never Married 2 M	arried				If Ye	es, specify Cuba	n, Mexican	, Puerto Rio	can, etc.)		White	, etc.	
Sequentially list conditions and in the same of the sa	ط ط			3 Midawad 4 Div	orood			lo	1	Vas a V N	o opocific				Coosific		
Sequentially list conditions and in the same of the sa	s aft	E ii	Ş			or Dates:		1) [40-				.: al a.c al					
Sequentially list conditions and in the same of the sa	nor	E and	g											16b. r	(ind of Bus	iness/ir	naustry
Agric Barrier Barrier Ba	24	# F	et	Elementary/Secondary (0-12)	- 1	College (*	1-4 or 5+)						•	1			
Agric Barrier Barrier Ba	B iff	きる	밁		-		3	Ac	coun	ting Te	chnic	ian		Ci	vil S	erv	ice
Annes Barnes / Mother 23955 Hollywood Rad Hollywood Rad Ho	Q 3 .5	he he	ē	17. Father's Name (First, Middle,	, Last)								irst, Middle, I				
Date Place of Disposition (Name of constatery, Date 20c. Location - City or Town, State 20c. Location -	2 9 5 5	it to	a)	Emmoth Hamilton	. D.		0				Aama	a II.a.h.1	L				
Date Place of Disposition (Name of constatery, Date 20c. Location - City or Town, State 20c. Location -	7 4 5 4 7	eve					Sr.	198	o Mailing	Address (Stre				nber Ci	ity or Towr	State	Zip Code)
Date Place of Disposition (Name of constatery, Date 20c. Location - City or Town, State 20c. Location -	shou	is						- 17		`					1		zip codo,
2.2 Name and Address of Facility Brinsfield Funeral Home, P.A.	∑ d 2 4 4 4 4	122			<u>the</u>	r	10	12	<u> 3955</u>	Hollywo	ood R	oad, j	Hollyw	pod	<u>MD</u>	20	
2.2 Name and Address of Facility Brinsfield Funeral Home, P.A.	6 1 4	2 1				Domoval f					emetery,	D	ate	200.1	Location -	City or	Town, State
2.2 Name and Address of Facility Brinsfield Funeral Home, P.A.	age:	글림			-	_ itemovarii				D		00/0	0 /0010		-		
Physician Modical Staminer Physician Modical Staminer Physician Modic	ir P	# 5						yueen	OI	Peace Co	em s of Facility	,					
Play ideas Control Column Colum	Ba Denn Denn			Tribbal los	~	_	_					Brin					ome, P.A.
Figure List only one cause on each line. Sequentially list cause / Final disease or condition resulting in death) Sequentially list cause / Final disease or condition resulting in death) Sequentially list cause / Final disease or condition resulting in death) Sequentially list cause / Final disease or conditions resulting in death Due to (or as a consequence of): Due to			-	Edward N. Brin	sfig	eld, J	r. MOO	052	1229	155 Holl	ywood	Road	Leona	ardt	own.	MD	
The minimal and cause (Final disease or condition resulting in death) Last to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Either Underlying Cause are the Underlying Cause as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Either Underlying Cause are the Underlying Cause as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Either Underlying Cause are the Underlying Cause							aused the de	atn. Do no	n enter tri	le mode of dying	, such as G	ardiac or re	spiratory arr	est, sno	JCK, OF FIE a	n	
Due to (or as a consequence of): Sequentially life conditions Due to (or as a consequence of):				Immediate Cause (Final disease	a.	Drowni	ng										Death
Sequentially list conditions in any leading to immediate has been consistent or the past 12 months? Sequentially list conditions List L	_Aaii	IIIICI		or condition resulting in death)	D	ue to (or as a	consequen	ce of):				,					
The first of the state of the s				Sequentially list conditions	b.												
AMENDED 23a,27,28a-f,per me,g924 2-15-12 Sm AMENDED 3a,27,28a-f,per me,g924 2-15-12 Sm AMENDED 3a,28a-f,per me,g924 2-15-12 Sm AMENDED 3a,28a			호	if any, leading to immediate		ue to (or as ε	consequen	ce of);									
AMENDED 23a,27,28a-f,per me,g924 2-15-12 Sm AMENDED 3a,27,28a-f,per me,g924 2-15-12 Sm AMENDED 3a,28a-f,per me,g924 2-15-12 Sm AMENDED 3a,28a			늴		C.												
AMENDED 23a,27,28a-f,per me,g924 2-15-12 Sm AMENDED 3a,27,28a-f,per me,g924 2-15-12 Sm AMENDED 3a,28a-f,per me,g924 2-15-12 Sm AMENDED 3a,28a	_	4	Xa		D	ue to (or as a	a consequen	ce of):									
Past 12 months?	cute	trans			_ d					limit							
Past 12 months?		ian a	<u>:</u>	X UNPENDED	X	AMENDED	23a,2	/,28a	-f,p	er me,g	924 Z·	-15-1	2 sm				
Past 12 months?	6 5 4	ysic	9	IE EEMALE:		4c.pe	ne g	925 3	1-8-1	2 sm				236	d Date of (delivery	
TO C 1900 and 1900 an	87.	ON ON			ne				Fet	aldeath 3	Ectopic	pregnancy	,	1-00		-	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 yes 2 No 3 Probably 4 Unknown		andir	흥	past 12 months?		4 Pregr	nant at time o										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 yes 2 No 3 Probably 4 Unknown	leath 🥱	for	S	1 Yes 2 No 9 Uni	known	9 Unkn	own		/ Out	lei (opcony)				ì			
The state of the s	the o	# 2	듄	Part II. Other significant condit	ions	contributing t	o death but n	ot resulting	in the ur	nderlying cause	given in Pa	rt I.	23e. Did to	bacco	use contrit	oute to t	he cause of death?
29b. Signature and title of certifier 29c. License number O.C.M.E. 29d. Date signed (Month, Day, Year) January 29, 2012 30. Name and address of person who completed cause of death (Item 23a) Victor Weedn MD JD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 State 31. Date filed (Month, Day, Year) 32 Registrar's Signature	D. that	deta		450 00 00 00						,,			1 \	2 🗸	No 3	Prob	ably 4 Inknown
29b. Signature and title of certifier 29c. License number O.C.M.E. 29d. Date signed (Month, Day, Year) January 29, 2012 30. Name and address of person who completed cause of death (Item 23a) Victor Weedn MD JD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 State 31. Date filed (Month, Day, Year) 32 Registrar's Signature	ires	1 sig	g														
29b. Signature and title of certifier 29c. License number O.C.M.E. 29d. Date signed (Month, Day, Year) January 29, 2012 30. Name and address of person who completed cause of death (Item 23a) Victor Weedn MD JD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 State 31. Date filed (Month, Day, Year) 32 Registrar's Signature	5 5	bee	<u>e</u>														
29b. Signature and title of certifier 29c. License number O.C.M.E. 29d. Date signed (Month, Day, Year) January 29, 2012 30. Name and address of person who completed cause of death (Item 23a) Victor Weedn MD JD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 State 31. Date filed (Month, Day, Year) 32 Registrar's Signature) §		튑										perfor	rmed?	de	eath?	
29b. Signature and title of certifier 29c. License number O.C.M.E. 29d. Date signed (Month, Day, Year) January 29, 2012 30. Name and address of person who completed cause of death (Item 23a) Victor Weedn MD JD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 State 31. Date filed (Month, Day, Year) 32 Registrar's Signature	& ₫	ficat , pag	ပ္ပု		-									2N	0 1	Yes	3 2 No
29b. Signature and title of certifier 29c. License number O.C.M.E. 29d. Date signed (Month, Day, Year) January 29, 2012 30. Name and address of person who completed cause of death (Item 23a) Victor Weedn MD JD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 State 31. Date filed (Month, Day, Year) 32 Registrar's Signature	<u> </u>	certi				sanital: res		_		26.Plac						_	
29b. Signature and title of certifier 29c. License number O.C.M.E. 29d. Date signed (Month, Day, Year) January 29, 2012 30. Name and address of person who completed cause of death (Item 23a) Victor Weedn MD JD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 State 31. Date filed (Month, Day, Year) 32 Registrar's Signature	<u> </u>	导			Inc	1 !	Inpatient 2	ER/O	utpatient	3 DOA	001814	Nursing H	fome 5	Reside	nce 6 🗸) Other:	Scene
29b. Signature and title of certifier 29c. License number O.C.M.E. 29d. Date signed (Month, Day, Year) January 29, 2012 30. Name and address of person who completed cause of death (Item 23a) Victor Weedn MD JD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 State 31. Date filed (Month, Day, Year) 32 Registrar's Signature	of of	nera		27. Manner of Death		28a. Date	of Injury	28b. 1	Time of In	ijury 28c. Inju	ury at Work				-		.1
29b. Signature and title of certifier 29c. License number O.C.M.E. 29d. Date signed (Month, Day, Year) January 29, 2012 30. Name and address of person who completed cause of death (Item 23a) Victor Weedn MD JD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 State 31. Date filed (Month, Day, Year) 32 Registrar's Signature	E indi	he fi	흥	Pend			-28-12	2 fd	10:30	oam 1	Yes 2 🗶	No S	ubject	: Ju	mpea	ınt	o the water
29b. Signature and title of certifier 29c. License number O.C.M.E. 29d. Date signed (Month, Day, Year) January 29, 2012 30. Name and address of person who completed cause of death (Item 23a) Victor Weedn MD JD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 State 31. Date filed (Month, Day, Year) 32 Registrar's Signature	Att Si	। ठ >∥	<u> 8</u>		-	28e Plac	e of Injury - /	At home, fa	rm, stree	t, factory, office	building, etc	c. 28	f. Location (S	Street_a	nd Numbe	r or Rur	al Route Number_City
29b. Signature and title of certifier 29c. License number O.C.M.E. 29d. Date signed (Month, Day, Year) January 29, 2012 30. Name and address of person who completed cause of death (Item 23a) Victor Weedn MD JD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 State 31. Date filed (Month, Day, Year) 32 Registrar's Signature	S To Ta	ed in	늰	dete		e					_	Τ.	or Town, S	tate) L	eonai	rdto	wn Whari
29b. Signature and title of certifier 29c. License number O.C.M.E. 29d. Date signed (Month, Day, Year) January 29, 2012 30. Name and address of person who completed cause of death (Item 23a) Victor Weedn MD JD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 State 31. Date filed (Month, Day, Year) 32 Registrar's Signature	J spit	E E	ပီ	4 Homicide		1											
29b. Signature and title of certifier 29c. License number O.C.M.E. 29d. Date signed (Month, Day, Year) January 29, 2012 30. Name and address of person who completed cause of death (Item 23a) Victor Weedn MD JD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 State 31. Date filed (Month, Day, Year) 32 Registrar's Signature	e Ho	e Fu	g	(Check only Gertifying Fi	nysicia	n: To the bes	st of my know	rledge, dea	th occurr	ed at the time, d	late and pla	ice, and du	e to the caus	e(s) an	d manner a	as state	d.
O.C.M.E. January 29, 2012 30. Name and address of person who completed cause of death (Item 23a) Victor Weedn MD JD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	Po th	d dwo	ğ	2 Medical Exa	miner:	and manner s	or examination takes the stated.	on and/or in	nvestigati	оп, іп ту оріпіо	n, death oc	curred at th	ie time, date	апо ріа	.ce, and du	e to the	cause(s)
30. Name and address of person who completed cause of death (Item 23a) Victor Weedn MD JD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 State 31. Date filed (Month, Day, Year) 32 Registrar's Signature		- "	Σ	- 1 11	1 X	0/	7///	2 Ad	1	29c. Licen:	se number			29d. [Date signe	d (Mon	th, Day, Year)
Victor Weedn MD JD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 State 31. Date filed (Month, Day, Year) 32 Registrar's Signature		1		1/10/50 11.	17	1/0	11/	1300		O.C.	M.E.			Jani	uary 29,	2012	
Victor Weedn MD JD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 State 31. Date filed (Month, Day, Year) 32 Registrar's Signature			}	20 Name and address of	who	-Vel	so of do-th (tom 22=1	_					l			
State 31. Date filed (Month, Day, Year) 32 Registrar's Signature							•		900 147	Raltimore 9	Street P	altimore	MD 2122	23			
Citale					73				JUU VV.		Julieut, De		2 122		-		
					004	- 4	egistrar's Sig	nature	600	11							

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 11 03 PM May 27 2012 Janice Balenger Medical 4a. Facility Name (if not institution, give street and number, **Examiner** 4b. City, Town, or Location of Death 4c. County of Death St. Mary's Hospital St. Mary's Leonardtown Social Security Number If Under 1 Year | If Under 24 Hrs. . Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Ye May 5, 1 9. Birthplace (State or Foreign **Funeral** Days Hours Min Director 72 Vrs 578-50-5116 1939 Washington. Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 X No Maryland St. Mary's Charlotte Hall 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be I Funeral 37760 Mohawk Drive 20622 USA 12. Was Decedent Ever in U.S. Was Deces? Armed Forces? Vas 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married 1 ☐ Yes 2 No Specify If Yes, Give Year or Dates 3 Widowed 4 Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) U.S. Postal Service Postal Carrier Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Earl Jonathan Vermillion Beulah Fletcher Bolev 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 424, Charlotte Hall, MD 20622 Gerald F. Balenger, Sr./Spouse 20a. Method of Disposition 20b Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place, 4 Departion 5 Other (Specify) 02/03/2012 Bryantown, Maryland Mary's Cemetery 21. Signature of Funeral Service Licenses 22. Name and Address of FacilityBrinsfield-Echols F.H., P.A. 30195 Three Notch Rd., Charlotte Hall, MD 20622 M00817 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition How Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) and Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 Dav Pregnant at time of death Yes No Unknown P.O. death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available page 2 autopsy prior to completion of cause of death? 1 Yes 2 No __ Yes Division of Vital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Certificate: To 1 Yes Other: Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home this 5 Residence 6 Other (Specify) funeral (27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No s after death. the f Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State) 24 hours a Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier completed (Check Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within ? 29b. Signature a 30. Name and a ause of death (Item 23a) (Type, Print) 25500 Point lookout Road, Leonardtonn 4 ene

Registrar DHMH 17 Rev 7/2009

State

31. Date filed (Mont

JAN 3 0 2012

PRIVANK DESAI MD.

State of Maryland / Department of Health and Mental Hygiene 2012 For State Registrar 2. Date of Death Physician/ Month 2012 Year Thomas Bradford January Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 43980 Hedgewood Lane California St. Mary's If Under 1 Year | If Under 24 Hrs. **Funeral** Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year, Director 217-46-6155 1 🖾 M 2 🗆 F 03/04/1949 62 28a-f show Examiner must be notified at 10b. County 10c. City, Town or Location Director Maryland St. Mary's California 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a 43980 Hedgewood Lane 20619 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 X No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Black, White, etc. other than "natural", or þ 1 Never Married 2 X Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Completed 3 Divorced Specify: Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) uld be filed within 7 I Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) School Administrator Public School System Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Thomas Bradford, Sr. Phyllis Lenora Odessa Upshur 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and 2 s Health item 27 Mary Alice E. Speed-Bradford 43980 Hedgewood Lane, California, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, injury or Donation 5 Other (Specify) 01/31/2012 Great Mills, Maryland Evergreen Memorial Strature of meral Service Lochice
Edward N. Brinsfield, 22. Name and Address of Facility Brinsfield Funeral Home, P.A. Уŕ. M00052 22955 Hollywood Road, Leonardtown, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final diabetes Concontrollad Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical that the death certificate be Box 68760 IE EEMALE use 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Pregnant at time of death 1 Yes 2 L 9 Unknown 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performed? Yes 2 No certificate Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 2 No ျ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🗶 Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death • Hospital or Attending Pl 24 hours after death. • Funeral Director; After th Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Accident 1 Yes 2 No Investigation 3 Suicide
4 Homicide

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

12:15 p.m.

Birthplace (State or Foreign Country)

10d. Inside City Limits

Onset and Death

Day

2 🗆 No

1 Yes

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Year

1 Yes 2 X No

Virginia

Black

5)eme State

24 hours

Medical

29a. Certifier

only one)

Registrar DHMH 17 Rev 06-2011 6 Could not be

determined

NH. Bunary, m.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BUNAVES, M.D; 225-90 Shady count,

1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

D21893

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

			Plea									_	ible.		
		For State		State of	Marylar		oartment of e <i>rtificate of</i> .		and N	/lental Hy	0010 0001				
		Registrar 1. Decedent's Name	e (First, Middle	, Last)			erinicate or	Deam		2. Date of De		0.	16	3 Time of Death	
Physicia		Christa		*						Month	_	3, 20	1^{Year}		
Medic Examin		, ,	,	give street and numb	,		4b. City, Town, o		f Death	1		c. County	of Death	•	
				edical Cer			Annap		2111			Anne			
Funeral Director		5. Social Security No. 215–82–7		6. Sex 1 □ M 2 🗶 F	7. Age (In yrs. I 75) If Under 1 Year Months Days		Min.				9. Birthp Count	lace (State or Foreign try)	
		Usual Residence o	of Decedent	I LIVI Z LA		Yrs.				3/6/19	936				
yland -f sho ed at	ctor	10a. State	10b. County			y, Town or I			2. Date of Death January 23, 2012 3. Time of Death January 23, 2012 4c. County of Death Anne Arunde1 4c. County of Death Anne Arunde1 3/6/1936 4c. County of Death Anne Arunde1 4d. County of Death Anne Arunde1 4d. County of Death Anne Arunde1 4d. County of Death Anne Arunde1 4d. County of Death Anne Arunde1 4d. County of Death Anne Arunde1 4d. County of Death Anne Arunde1 4d. County of Death Anne Arunde1 4d. County of Death Anne Arunde1 4d. County of Death Anne Arunde1 4d. County of Death Anne Arunde1 4d. County of Death Anne Arunde1 4d. County of Death Anne Arunde1 4d. County of Death Anne Arunde1 4d. County of Death Anne Arunde1 4d. County of Death Anne Arunde1 4d. Lace - American Indian, Black, White, etc. 4d. Race -						
or 28a notifi	Director	Maryland 10e. Street and Nun		Arundel	l P	dgewa	10f. Zip Code				100.0	Pitizon of M	Vhat Coun		
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at ance.	Funeral	3945 Rams		ve			210		rog. c			uy.			
items		11. Marital Status		12. Was Deced	lent Ever in U.	S. 13	B. Was Decedent of H	Hispanic Orig	jin? (Spe	ecify Yes or No-	-				
after o	d by	1 ☐ Never Marri		If Yes, Give			1 ☐ Yes 2 🛣 No		, , , , , , , , , , , , , , , , , , , ,	Tillouri, otoly					
nours natura ical E	Completed	3 🗆 Widowed		Year or Dat t's Education	es.	16a. Dec	cedent's Usual Occu	pation			16b				
in 72 e. nan "r	duc	(Spe		st grade completed) College (1-4	1 or 5+)	life.	re kind of work done DO NOT use retired	during most)	of work	ing					
d with lygien ther ti nt, the	To Be Con	12th				Pas	try Chef							ce	
be file ental F ked of		17. Father's Name (I	rirst, Middie, L nan Duh)		
ind Me		19a. Informant's Na	ame/Relationsh	nip (Type, Print)		19b. Ma	illing Address (Street	and Number	r or Rura	al Route Numbe	er, City c	or Town, St	tate, Zip C	Code)	
nd 2 sl ealth a n 27 i e r tra		Werner E.	. Brand	t/ Husband	l	39	45 Ramsey	Drive	e, E	dgewate	er, N	MD 21	037		
gelar tofHe Ifiter or oth		20a. Method of Disp	oosition X Cremation	3 Removal from S	State	cemetery, cr	position (Name of ematory or other pla	ice)					•		
iit. Pag irtmen irtant: injury		4 Donation 21. Signature of Fyri	5 Other (S	pecify)	K		Crematory	i							
permi Depar Impoi any ir once.		I Signature of the	AR L	icerisee						_					
		23a. Part 1. Enter t	the disease, or	complications that can	used the deat	h. Do not e						<u> </u>		Approximate	
Physician/		Immediate Cause (disease or conditio	(Final	Tsch	emic	bou	el								
Medical Examiner		resulting in death)		Due to (c	r as a conseq	uence of):	/ .								
	ner	Sequentially list co if any, leading to im	nmediate 💹	b. Due to (c	r as a conseq	uence of):	mboli viluse						-		
e executed sian and urial-transit	Examiner	cause. Enter Under Cause (Disease or that initiated events	injury	REJA	ilato	y f	a luse								
e executed ian and urial-transi		resulting in death) l		Due to	r as a conseq	uence of):									
ate be physic the b	edica	d											\pm		
eath certificate be e attending physicie d for use as the bu	Physician/Medical	IF FEMALE: 23b. Was decedent	pregnant	23c. If yes, outc			Π					23d. Dat	e of delive	ery	
death ne atte ed for	sicia	in the past 12 r	No		ant at time of		Ectopic pregnar Other (specify)	icy				Mor	nth	Day Year	
requires that the des been signed by the s should be detached	Phy	9 Unknown		ns contributing to de		sulting in the	underlying cause o	iven in Part I		220 Did	tahaaaa		huta ta th	an anuma of dant#2	
res tha signed d be d	Completed by	Atria	1 fil	in continuing to do		verting in the	o undonying oddoo g	TVOTTITT CITET						4	
required to the second should	lete									24a. Was	an				
The law ate has page 2	mo									_ perf	ormed?	d	leath?	_	
ysician: T is certifica director, p	Be C	25. Was case referre	ed to medical						h <i>(Checl</i>		2 4/1	10		2	
Physic this ce	은		No h	Hospital: 1 1 I		ER/Outpat	ient 3 DOA Oth	4 ∐ Nu	$\overline{}$						
iding I th. After funer	Certificate:	1 Natural 2 Accident	5 Pendin	g (Month	n, Day, Year)	injury	wor			28d. Describe	how inju	iry occurre	d		
Atter er dea ector by the	ərtifi	3 Suicide	6 Could	not be 28e. Place of	of Injury - At hog, etc. (Specif)		street, factory, office						r or Rural	Route Number,	
nital or urs aft ral Dir illed in															
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 brows after death certificate be within 24 brows after death. To the Tutheral Director, After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the but the funeral director is a specific to the funeral director.	Medical	(Check 2	Medical E	xaminer: On the basis	of examinatio	n and/or inv	estigation, in my opin	ion, death oc	curred at	t the time, date	and plac	e, and due	to the cau	use(s) and manner stated	
To the within To the Comple	Σ	only one) 3 29b. Signature and		Nurse Practitioner.	TO the best of t	ny knowledi	29c Licens		e anu pie	ace, and due to		ate signed			
)		▶ Loc	the	mson a	RNP		1 / 13	1186			_ //	123/	12		
1110		30. Name and addre	ess of person v	who completed cause	.1.		NII	./	A	1,4 .17	1	3.	14 .		
AT W Stat		31. Date filed (Month	h, Day, Year)	32. P4	gistrar's Signa	ture .	ray.	MANN	4/10	111 10	1d	. 41	401		
Stal			14N 2 6	2012 6			ha. N. I								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar AMEND#2perMD, 1/19/12; BMW, MoCo Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Monudanuary av15, 2012 Physician/ 6:10pm Medical 4a. Facility Name *(if no* Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Potomac 9. Birthplace (State or Foreign Country) Arizona 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Days Months (Month, Day, Year) 01/01/1910 Director 102 Usual Residence of Decedent iral", or items 23a or 28a-f shov Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho ury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Bethesda Maryland Montgomery 1 Tes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20817 U.S.A. 10250 Westlake Drive, #913 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Force Completed by 1 Never Married 2 Married 1 ☐ Yes 2 🗶 No Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 Divorced Specify: White 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Automobile Elementary/Seconday (0-12) College (1-4 or 5+) 12 Office Secretary/Treasurer Sales & Repair Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Guy Nelson Garner Gertrude Greeson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PO Box 429, 9495 Lovat Road, Fulton, Maryland 20759 Guy M. Hawkins - Nephew Department of Healt Important: If item 2 any injury or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State ☐ Burial 2 🕱 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Crematory 01/24/2012 | Brentwood, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. auecvarrer 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Inanition disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): attending physician and for use as the burial-the Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time of death

Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 X No 5 Other (specify) signed by the a d be detached f 1 ☐ Yes 2 d Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Atrial Fibrillation Division of Vital Records, 1 ☐ Yes 2 🗓 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2 s autopsy prior to completion of cause of death? Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 X No ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 🛮 Nursing Home 5 🗌 Residence 6 🗀 Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending injury work? 1 Yes 2 No Investigation 6 Could not be Accident Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number. determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D50534 omas January 16, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6858 Old Dominion Drive, #104, McLean, Virginia 22101 Thomas Masterson, M.D. Date filed (Mon State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month JAN. Day 2012 WALTER BARNES 5:20 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death WASHINGTON ADVENTIST HOSPITAL TAKOMA PARK MONTGOMERY 5. Social Security Number 8. Date of Birth (Month, Day, Ye 6. Sex 1 X M 2 □ 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Funeral 9. Birthplace (State or Foreign Min. LOUISIANA Months Hours Director 435-38-8867 79 Usual Residence of Decedent "natural", or items 23a or 28a-f show idical Examiner must be notified at and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Health and Mental Hygiene. tem 275 is marked other than "natural", or items 23a or 28a-f show their traumatic event, the Medical Examiner must be notified at their traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1√2 Yes 2 □ No D.C. NONE WASHINGTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3700 NORTH CAPITOL ST N.W. 20011 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces? 1 Never Married 2 Married Black, White, etc. Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: 3 Divorced 4 Divorced 1971 Year or Dates BLACK 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) U.S. ARMY **DEFENSE** Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 **GEORGE** BARNES LULUA KEASLEY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 any injury or other the ERIC P. BARNES/SON 6323 57th AVE., RIVERDALE, MD. 20737 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State ARMED FORCES RET (ace) HOME CEM 4 ☐ Donation 5 ☐ Other (Specify) 2-2-2012 WASHINGTON, D.C. 21. Signature of Funeral Service Licensee CHAMBERS FUNERAL HOME & CREMATORIUM, P.A. hound M00091 5801 CLEVELAND AVE., RIVERDALE, MD. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition ACUTE MYO CARDIAC Medical resulting in death) Due to (or as a consequence of) Examiner DISEASE OROWAPY ALTER Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and been signed by the attending physician and should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Certificate: To Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Day Month Year Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? DIAGETES 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 1 Unknown SEPSIS 24b. Were autopsy findings available prior to completion of cause of death? autopsy REWAL FAILURE performed' Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific.

Completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 💆 No Other: 1 Inpatient 2 ER/Outpatient 3 I DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

Registrar

27

DHMH 17 Rev 7/2009

29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

500216

TERRY JODRIE, MD, FACEP

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

D40324

7600 CARROLL AVENUE, TAKOMA PALK, MARY LAWD

29d. Date signed (Month, Day, Year)

JANUARY 13, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 03820 State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ January HARRY BAKER WESLEY Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** DOCTORS COMMUNITY HOSPITAL LANHAM PRINCE GEORGES Social Security Number If Under 1 Year If Under 24 Hrs. . Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Min. Davs Hours (Month, Dav. Year, Director 219-90-4463 1 **X** M 2 □ F 49 APRIL 26,1962 PA. Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10d. Inside City Limits 10c. City. Town or Location Director 1 Yes 2 ☐ No MD. PRINCE GEORGES COLLEGE PARK 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? the Medical Examiner must be Funeral items 23a 9703 49th PL 20740 U.S.A. within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Was Decede... Armed Forces? Yes 2 X No 14. Race - American Indian, Black, White, etc. ō þ 1 X Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. "natural", Specify: 3 Divorced 4 Divorced Completed WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 10 TREE CUTTER TREE SERVICE other Be other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) is marked of . Page 1 and 2 should be fill tment of Health and Mental tant: If item 27 is marked o 2 HARRY Α. BAKER DOROTHY McMASTERS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 60th AVE., HYATTSVILLE, MD. 20781 NANCY BELLAMY/SISTER 5014 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 💢 Cremation 3 ☐ Removal from State Department or Important: If any injury or once. injury or 4 Donation 5 Other (Specify) CHAMBERS CREMATORY 1-24-2012 RIVERDALE, MD. 21. Signature of Funeral Service Licenses CHAMBERS FUNERAL HOME & CREMATORIUM, P.A. unke M00091 5801 CLEVELAND AVE., RIVERDALE, MD. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ Hepatic encephalopath disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner irchosi Sequentially list conditions, Examine cause (Disease or injury To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): signed by the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 38 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ page 2 should be 1 Yes 2 9 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has autopsy performed Yes 2 4 No 2 No To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 4 No Other: 1 Thipatient 2 -ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural (Month, Day, Year) 5 Pending 1 ☐ Yes 2 ☐ No completely filled in by the ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier MD 23/2012 D0068976

Registrar

DHMH 17 Rev 06-2011

State

Doctors Community

LANHAM, MICK

Hospital

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

JAN 2 6 2012

Beyene

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 810 STINA 12 Medical Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 8. Date of Birth (Month, Day, Yea Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗹 F Hours Min. Country) PA. Director show 10a. State 10c. City, Town or Location 10d. Inside City Limits notified at Director 28a-f 1 Tyes 2 No ANNEARUNDE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? #ms 23a or r must be r ö Funeral 1.5.A Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mus Page 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces? Black, White, etc. <u>Ş</u> 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced Specify: WhITE Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) DRSINO ERISTERED Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname မ IARIA TAR 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) B. MC DERMOTT SEVERNA PARK 138BENFIELD 21146 MD. Baltimore, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 5-12 4 ☐ Donation 5 ☐ Other (Specify) ODENTON, MD. permit. of Funeral Service Licens 22. Name and Address of Facility DAUGNERTY FUNERAL HOME 2601 MOUNTAIN RA M00942 Part 1. Enter the dease, or plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Ph_sician/ Due to (o) as a consequence of): (now) disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician for use as the buria Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate bewithin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the bur P.O. Box 68760 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Month Day Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 3 Probably 4 Unknown 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed Yes 2 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 2 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death Medical Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 5 Pending injury 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print) Columbia 32. Registrar's Signature State FEB 1 0 2012

Registrar

12-01027 John Demos Caiopoulos amend 23a,pt.II,27,28a-f,per me,g924 2-15-12 sm
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

lease Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.				
State of Maryland / Department of Health and Mental Hygiene	0	0	1	-

ohn Demos Cai		1- For State	Maryland / Departn Certific	nent of		and	Mental	l Hygiene	Reg. No.	201	2	03822
Physicia		Registrar 1. Decedent's Name (First, Middle,Last)				_		2. Date of D	eath	Vees	3. Time	of Death
Medical Examir	1er	John Demos Caiop							y 3, 201			5 hrs
1		4a. Facility Name (if not institution, give street 9442 Carriage Hill Street	eet and number)	4	b. City, Tow Frederi		cation of D	eath		County of Dear rederick	th	
Funeral Director		Social Security Number 6. Sex	7. Age (In yrs. last b	irthday)	If Under 1 Months	Year Days	If Under 24 Hours	4Hrs. 8. Date of Min.	Birth (MM/D	D/YYYY) 9. B	irthplace (ign Was	State or hington D.C.
Director		214-98-6997 1 XM Usual Residence of Decedent	2 F 44	Yrs.				Decem	ber 1	8,196/c	ountry)	D.C.
any		10a. State 10b. County	10c. City, Tow	n or Locatio	on			-			10d. Ins	ide City Limits
	٦	Maryland Frederick	Fred	derick	C						1 🔲	res 2 X No
th the Maryland 23a or 28a-f sho notified at once	Directo	10e. Street and Number 9442 Carriage Hill	Street		10f. Zip Co 217					en of What Col	untry?	
3, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland featth and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f ahe traumatic event, the Medical Examiner must be notified at once	uneral	11. Marital Status 1 Never Married 2 Married	. Was Decedent Ever in U.S. Armed Forces?					(Specify Yes or uerto Rican, etc.)	No- 1	14. Race - Ame White, etc.	rican India	ın, Black,
fter de	╙┃	3 Widowed 4 Divorced If Ye	Yes 2 X No ss, Give Year lates:	1	Yes 2XX	No s	pecify:		S	Specify: Wil	nite	
ours a	od be	15. Decedent's Education (Specify only hi	ghest grade completed) 16a		s Usual Oc			of work done	16b. Ki	nd of Business	/Industry	
D36 thin 72 hae. • than "r	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)		edigat		31401 400	, roured,	Co	nstruct	tion	
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hou Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nati	Be Cor	17. Father's Name (First, Middle, Last) James Caiopoulos	<u> </u>			18.		ame (First, Middle ie Feite		Gurname)		
212 ould bould by Ment s mark	일	19a. Informant's Name/Relationship (Type,						or Rural Route N				
MD and 2 should hand and 27 is a number of 15 is		James Caiopoulos -				_		Street,		2.1	/04	
Ore, ges lau of Hea If ite		1 Burial 2 Cremation 3 F	Removal from State crema	atory or other				Date		ocation - City o		
Baltimore, permit. Pages I an Department of He Important: If ite Imjury or other training to the training the content of the training or other training or o		4 Donation 5 Other Specify: 21. Squature of Funeral Service Licensee	Mt. (Ceme			-8-2012		derick		yrand
Depa Depa Injur		Maron Cepuiles	Colina	- 1			-	Stauffer Pike, Fr				d 21702
Physician	9	3a. Part I. Enter the disease, or complicating failure. List only one cause on each line.			_						Approx	kimate Interval
/Medical Examiner		Immediate Cause (Final disease a. Ox	ycodone Intoxi	catio	n							Death
		Sequentially list conditions, b										
	Examiner	cause. Enter Underlying Cause	to (or as a consequence of):									
si, d	Xan	events resulting in death) Last	to (or as a consequence of):									
an scr	adical E	d									+	
be be		IF FEMALE: 23	3c. If yes, outcome of pregnancy	,					234	Date of deliver	<u> </u>	
5876 rtificating ph	a Z	23b. Was decedent pregnant in the past 12 months?	Live birth		al death	3 🔲	Ectopic pre	egnancy			y Day	Year
Box 6876(death certificate he attending phys d for use as the b	Physician/M	1 Yes 2 No 9 Unknown 9	=	5 Oth	er (Specify)							
O. B		Part II. Other significant conditions conf		ng in the un	iderlying cai	use give	n in Part I.	23e. Dio	I tobacco us	se contribute to	the cause	of death?
of Vital Records, P.O. ag Physician: The law requires that the this certificate has been signed by meral director, page 2 should be detact	d b	Cocaine Use; Hyper	tensive Cadrio	vascu	lar D	isea	ise	11	'es 2	No 3 Pro	bably 4	Unknown
rds requi	Completed							24a. Wa	is an			lings available of cause of
Recol The law cate has page 2 sl								_ _ per	formed?	death? 1 ✓ Y		2 No
tal Rection: The certificate ector, page	Be .	25. Was case referred to medical			26.F			eck only one)				
Vit.	اع	examiner? 1 ✓ Yes 2 No	,	Outpatient				ursing Home 5		ce 6 🗸 Othe	er: Scene	
n of	崩	1 Natural	(Month, Day, Year)	Time of Inj	· 1 .	_ `	t Work? 2 🛣 No	28d. Describ		y occurred		
Division tal or Attendi rs after death. al Director: A led in by the ft	cati	2 Accident Investigation	fd 2-3-12 fd 28e. Place of Injury - At home, to	05:30	y più					d Number or Ri	ural Pouto	Number City
Divi	Certification:	Suicide S La Could not be	(Specify) Found: Res	•		ioo bana	ing, o.o.		State)94	<u>4</u> 2 Carr		hill St.
		29a. Certifier 1 Certifying Physician: 1	o the best of my knowledge, de			e, date a	and place,				ted.	
To the Howithin 24 P. To the Fuccompletely	ጄ L	one) 2 Medical Examiner: On tand	he basis of examination and/or manner stated.	investigatio				ed at the time, da				
	Σ	29b. Signature and title of certifier				ense nu				ate signed (Mo		(ear)
		hylwis			\perp $^{\circ}$.C.M.E	1 .		⊢ebru	uary 4, 201:		
6		 Name and address of person who complete Ling Li, MD Assistant Medic 	eted cause of death (Item 23a) cal Examiner 900 W. E		Street, I	3altim	ore, MD	21223				
Sta	ite	31 Date filed (Month - Day Year)	32 Régistrar's Signature	- A	Ked							
Registr	ar	FEB 0 7 2012	flerena fil.	Egran	1							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 20Î2 6:00 P M January Charles Grayson Clements Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 22415 Gore Street Leonardtown St. Mary's 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** If Under 1 Year If Under 24 Hrs. Months Days 91 1 🗶 M 2 🗆 F **Director** 231-03-9163 10/ 07/ 1920 Virginia Usual Residence of Decede 10a. State with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits Director notified 28a-f 1 Yes 2 X No Maryland St. Mary's Leonardtown 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? must be i Funeral 22415 Gore Street 20650 United States Page 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, er than "natural", or ite Black, White, etc. þ 1 X Yes 2 □ No If Yes, Give Year or Dates. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: White Completed 3 X Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Train Engineer Transportation alth and Mental Hygien 27 is marked other tl r traumatic event, the 10 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Charles Clements Dora Duff 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is any injury or other trau Barbara Layne – Daughter 56 Gable Drive, Lynchburg, Virginia 24502 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Brinsfield Echols 01/30/2012 Charlotte Hall, Maryland 22. Name and Address of Facility Brinsfield Funeral Home P.A. Signate of Eureral Service Cantivosci

Kathleen A. Santivasci M00872 22955 Hollywood Road, Leonardtown, Maryland 20650 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. , such as cardiac or respiratory arrest, Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Exami transi-Cause (Disease or injury that initiated events and Due to (or as a consequence of): burial-t resulting in death) Last attending physician Physician/Medical that the death certificate be P.O. Box 68760 the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day Pregnant at time of death
Unknown signed by the at Id be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? <u>\$</u> Division of Vital Records, To the Hospital or Attending Physician: The law requires 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy perform within 24 hours after death.

To the Funeral Director: After this certificate 1 Yes 2 1 Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one. examiner? 2 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury Natural 5 Pending 1 🗌 Yes 2 \square No the Accident Investigation 6 Could not be Suicide 28e. Plr ce of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Medical Certifying Physicish: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examination the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check Certifying Nurs Pactitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of ce . Dav. Yearl

5teme

State Registrar 30. Name and addres

31. Date filed Month, Day

James

of person

JAN 3

Boyb

M.D

41680 Miss Bessie Drive,

Suite 301,

Leonardtown,

Maryland

who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 03824 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2012 Joseph Elwood Cusic, Sr. January 12:30 p M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death St. Mary's The Village at Taylor Farm Bushwood Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Year) Days 577-26-0562 **Director** 1 XM 2 - F 94 Yrs 12/31/1917 Maryland Usual Residence of Deceden 28a-f show ms 23a or 28a-f sho must be notified at 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Mechanicsville **Maryland** St. Mary's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 26765 Three Notch Road 20659 USA items 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. ō by 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. Maryland 21215-0036 nan "natural", Medical Exar 1 ☐ Yes 2 X No Specify Specify: White Completed 3 X Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the should be filed with and Mental Hygien is marked other th 8 Farm Manager Farm Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 traumatic John Quincy Cusic Nora Catherine Bussler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) e 1 and 2 sl of Health a If item 27 is Robert L. Cusic / Son 26765 Three Notch Road Mechanicsville, MD 20659 other t Baltimore, Department of Hear Important: If itemany inition 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 02/02/2012 Joseph's Catholic Morganza, Maryland ure of Funeral Service 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. 41590 Fenwick St., Leonardtown, MD 20650 tardene 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician estive disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Exami death certificate be executed and resulting in death) Last Due to (or as a consequence of): physician buria Physician/Medical Box 68760 the as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ P in the past 12 months? Dav Pregnant at time of death 2 No ed by the a detached 9 Unknown Unknown P.O. I that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Nown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has autopsy certificate l 2 No Yes 1 Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? filled in by the funeral director, Be Assisted 26. Place of Death (Check only one) 1 ☐ Yes 2 🔀 o Hospital Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Nother (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1.8 Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No after death. 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hor To the Fune completely fi (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29d. Date signed (Month. Dav. Year)

State Registrar 31. Date filed (Month, Day, Year

FEB 0

5) Rine

Three No tch Rd

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

28103

gistrar's Signature

D62042

101

Ste

30/

Mechanics ville MD 20659

			Please Type or Print i State of Maryl	and / Depa	artment of Health an	•	•	0000
	Physicia Medic		Registrar 1. Decedent's Name (First, Middle, Last) Joyce Darlene Con	nelly	tificate of Death	2. Date of Dea Month Januar	y 29, 2012	3. Time of Death 1321 M
	Examin	er	4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Location of D Fort Washing		4c. County of Death	
	Funeral		Fort Washington Hospital 5. Social Security Number 6. Sex 7. Age (In y	rs. last birthday)	If Under 1 Year If Under 24	Hrs. 8. Date of Birth	g. Birth	place (State or Foreign
	Director		218-78-0045 1 □ M 2 🛣 F 5	4 Yrs.	Months Days Hours M	Min. (Month, Day, 12/13/1		Maryland
	nd how at	اۃ	Usual Residence of Decedent 10a. State 10b. County 10c.	. City, Town or Loc	eation			10d. Inside City Limits
	faryla 8a-f s tified	ect	Maryland St. Mary's	Lexingt	on Park			1 🗌 Yes 2 🕱 No
	a or 2		10e. Street and Number		10f. Zip Code		10g. Citizen of What Cou	intry?
	h with ns 23: must	Funeral Director	45911 Charles Way		20653		US	
40	r deat or iten niner r	by Fu	11. Marital Status 12. Was Decedent Ever in Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 ☒ No		Vas Decedent of Hispanic Origin? f Yes, specify Cuban, Mexican, Pi	? (Specify Yes or No- uerto Rican, etc.)	14. Race - Amer Black, White	
036	s afte ral", c	q pe	3 Widowed 4 Divorced Year or Dates.	1	☐ Yes 2 🛣 No Specify;		Specify:	hite
21215-0036	2 hour "natu edical	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	lent's Usual Occupation	workina	16b. Kind of Business/l	ndustry
121	thin 7	Som	Elementary/Secondary (0-12) College (1-4 or 5+)	life. DO	O NOT use retired)		Own Hom	_
	e filed within 7 tal Hygiene. ed other than event, the M	Be	17. Father's Name (First, Middle, Last)	HC	omemaker 18. Mother's	Name (First, Middle, N		e
/lan	d be fi Aental arked ttic ev	입	Burton Benedict Ral	.ey	Franc	ces F1	orene H	ayden
Maryland	should and N is ma		19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	g Address (Street and Number o	r Rural Route Number,	City or Town, State, Zip	Code)
	and 2 Health em 27 ther tr		John Benedict Connelly/Son 20a. Method of Disposition		30 FDR Boulevar			
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		1 🗷 Burial 2 ☐ Cremation 3 ☐ Removal from State	b. Place of Dispos cemetery, cren Charle	natory or other place)	Date	20c. Location - City or 7	
iţi	artme ortan injuny		4 ☐ Donation 5 ☐ Other (Specify) 21 Signary of Funeral Service Licenses	G	ardens UZ	/03/2012	Leonardtov	
Ä	permil Depar Impor any in		Thickael Landiner		Name and Address of Facility Mattingley—Gard 41590 Fenwick S	iner Funer t., Leonar	al home, P. dtown, MD 2	A. 20650
	Physician/ Medical		23a. Part 1. Enter the disease, or complications that caused the cand shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as Joons	and		diac or respiratory arre		Approximate Interval Between Onset and Death
09.	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a constitution of the constitutio		actory de	sense		
. Box 68760	that the death certificate be led by the attending physic e detached for use as the be	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pre 1 Live Birth 2 4 Pregnant at time 9 Unknown	Fetal death 3	Ectopic pregnancy Other (specify)		23d. Date of deli	very Day Year
ls, P.O.	uires that t n signed b uld be deta		Part II. Other significant conditions contributing to death but not	t resulting in the u	nderlying cause given in Part I.	į .	bacco use contribute to	
Records,	sician: The law require certificate has been si lirector, page 2 should	Completed by	Hypertensin Dialettes m	ell	tis	24a. Was a autops perfor	prior to co	opsy findings available ompletion of cause of
tal	cian: ertifica ector,	Be	25. Was case referred to medical examiner? Hospital:		26. Place of Death (
of Vital	Physicia this certi ral direct	은	1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 27. Manner of Death 28a. Date of injury	28b. Time of	t 3 DOA Other: 4 Nursin		ence 6 Other (Special	y)
n o	iding Fith. After	cate	1 Natural 5 Pending 2 Accident Investigation		work? M 1 Ves 2 No		ow injury occurred	
Division	ne Hospital or Attendir n 24 hours after death. e Funeral Director: Af oletely filled in by the fu	Il Certificate:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - A building, etc. (Spe	at home, farm, streecify)			reet and Number or Rura n, State)	al Route Number,
_	To the Hospital or A within 24 hours after To the Funeral Direct completely filled in by	Medical	29a. Certifier (Check only one) 1	ation and/or invest	igation, in my opinion, death occur death occurred at the time, date a	red at the time, date an nd place, and due to th	d place, and due to the ca e cause(s) and manner as	ause(s) and manner stated stated.
	5 v v v v v v v v v v v v v v v v v v v		29b. Signature and title of certifier	1.	29c. License number H0055958	2	29d. Date signed (Month)	/ Day, Year)
Ď	•		30. Name and address of person who completed cause of death (Item 23a) (Type, P			7///	20653
(2)	pme		Katherine A. Martin, D.O.		South Shangri-L	a Drive, L	exington Pa	
	Stat Registra		31. Date filed (Month, Day, Year)		ale			

Registrar DHMH 17 Rev 06-2011 12-00447 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Robert Clayton Colwell State of Maryland / Department of Health and Mental Hygiene 2012 03826 1- For State Certificate of Death 1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Physician/ Month Day January 15, 2012 **Medical Examiner** ROBERT CLAYTON COLWELL 2132 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death 3810 Ralph Road Silver Spring Montgomery 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Funeral Months Days Hours Director Country) PA 217-70-7769 1 X M 54 11/22/1957 Usual Residence of Decedent 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No tem 27 is marked other than "natural", or items 22a nr 28a-f sho traumatic event, the Medical Examiner must be notified at once. Silver Spring MD Montgomery Director 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country 3810 Ralph Road 20906 USA Funera 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 X Married 2 1 X Yes Yes. Give Year unk 3 Widowed 4 Divorced 1 Yes 2 No specify Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12th Courier Service Self Employed 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Alfred Clayton Colwell Joan Izzi 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sandra Colwell/wife 3810 Ralph Road, Silver Spring, MD 20906 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State crematory or other place) Ardent Cremation Svc 01/19/2012 Hanover, MD Dongtion 5 Other Specify 22. Name and Address of Facility Snowden Funeral Home 21. Signature of Funeral Service(Lice) 246 N. Washington St. Rockville, MD 20850 Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** failure. List only one cause on each line Between Onset and /Medical Death a. Intra-Oral Shotgun Wound Immediate Cause (Final disease Examine or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Urcate has been signed by the attending physician and page 2 should be detached for use as the burial - transit Due to (or as a consequence of): certificate be executed Physician/Medical UNPENDED **AMENDED** Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of deliver 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Month Fetal death Dav Year past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. <u>۾</u> 1 Yes 2 ✓ No 3 Probably 4 Unknown Completed 24a Was an 24b. Were autopsy findings available autopsy prior to completion of cause of this certificate has ✔ Yes 2 No 1 Yes To the Hospital or Attending Physician: 25. Was case referred to medical 26.Place of Death (Check only one) Be Hospital: 1 inpatient 2 Other Nursing Home 5 Residence 6 Other Scene ER/Outpatient 3 DOA 1 Yes 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: Jan 15, 2012 Subject shot self Natural 2130 hrs 1 Yes 2 ✔ No 5 Pending death the Director: Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 V Suicide Could not be or Town, State) 3810 Ralph Road, Silver Spring, MD determined (Specify) Single Family Home 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 24] 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registral
DHMH 17 Rev 1/2001

OCMF 2006

State

30. Name and address of person who completed cause of death (Item 23a)

Deputy Chief Medical Examiner

Registrar's Signatur

Jack Titus MD.

31. Date filed (Month, Day Year)

O.C.M.E

900 W. Baltimore Street, Baltimore, MD 21223

January 16, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Valdez Calderon Mran . 18 Pay 2012 Year 0100 Javier Enrique Medical Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Takoma Park Examiner 4c. County of Death Montgomery Washington Adventist Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 6. Sex 1 M 2 □ F 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Days 593-64-9662 Hours 7908919950 Gwatemala Director Usual Residence of Decedent 28a-f show 10a State 10h County 10d. Inside City Limits 10c. City, Town or Location Examiner must be notified at Director Prince George's Adelphi Md 1 Yes 2 No 10f. Zip Code 20783 10e. Street and Number 10g. Citizen of What Country? items 23a Funeral 8216 14th Avenue Guatemala 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 14. Race - American Indian Black, White, etc "natural", or 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Completed by 3altimore, Maryland 21215-0036 White 1 X Yes 2 □ No 3 Widowed 4 Divorced Specify Year or Dates Important: If item 27 is marked other than "natu any injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)
Disabled 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) none Be 17. Father's Name (First, Middle, Last) 1 and 2 should be filed f Health and Mental H item 27 is marked otl 18. Mother's Name (First, Middle, Maiden Surname) Elena Calderon Juan Antonio Valdez ^{19a.} Informant's Name/Relationship (Type, Pript)
Guillermo Valdez/Nephew 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20169 3485 James Madison Highway Haymarket, Va 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State. Chacte, San Luis Peten, Guatemala Date permit. Page 1 a Department of 8 Ceffettery to Of the Chacte 1 XBurial 2 Cremation 3 X Removal from State 1/24/2012 4 Dorpation 5 Other (Specify) 21. Signatore of Funeral Service License PHNETEPADESSRINALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring, Md20910 . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ Due to (or as a consequence of): disease or condition resulting in death) Medical Examiner Aspivation Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): ending physician a use as the buria-Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No for Month Day Year signed by the a d be detached for 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Completed 1 ☐ Yes 2 Ø No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 🗹 No Other: ၉ 1 M Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28d. Describe how injury occurred 28c. Injury at 1 Natural 5 Pending 1 Tes 2 🗌 No

Box 68760 P.O. Records, Division of Vital Hospital or Attending Physician: s after death. filled in by the within 24

To the Fun.

COTT

COTT

COTT

The file.

2 Accident
3 Suicide
4 Homicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one Ä Certifying Nurse Prantioner: To the best of my knowledge, death d at the time, date and plane 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) ahort

State Registrar

ical

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Lylla Shahah

31. Date filed (Month,

72441

Takoma Pak: MD

8

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 03828 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Theodore Clifton Copper January 0900 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Hospital Easton attaston Memorial lalbot 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 216-40-4695 Days Hours Director 1 XM 2 □ F 67 June 15,1944 Md. Usual Residence of Dec ral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits 10a. State 10c. City, Town or Location Director ¥ Yes 2 ☐ No Md. Talbot Easton 10g. Citizen of What Country? 10e. Street and Numbe 10f. Zip Code Funeral Apt.8b Lee Terrace 21601 USA ortant; If item 27 is marked other than "natural", or items injury or other traumatic event, the Medical Examiner mu 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2X No If Yes, Give (00PCr, 1 Mcclore Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: Black 3 Widowed 4 X Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) associate restaurant permit. Page 1 and 2 should be filed wi Department of Health and Mental Hygie Important; If item 27 is marked other any injury or other trained. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Lester Stanton Bernice Copper 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dionne M. Hardy/daughter 18648 Ten Terra Way Brookeville, Md. 20833 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State 1X Burial 2 Cremation 3 Removal from State Richards Mem Prk 2/4/2012 Easton, Md. 4 Donation 5 Other (Specify) P.O.BOX 27 21. Signature of Mineral Service Licensee 22. Name and Address of Facility Harris-Nock Fnrl Srvcs Bridgeville 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ Widely Metastatic resulting in death) Medical Due to (or as a consequence of) **Examiner** DPD Sequentially list conditions, Examine it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Sepsic and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be. 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physicis P.O. Box 68760 the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Li Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant at time of death Month Year signed by the a 1 L Yes 2 L 9 D Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has to page 2 s autopsy performed? 1 Yes 2 No funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital ည 1 Yes 2 1 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Man of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury accurred injury 5 Pending Natural work?
1 Yes 2 No Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 3 🗆 within 2 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MN D006956 Jan, 20, 2012 Than 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Memorial Hospital of Easton Easton, Maryland MOhan 247 31. Date filed (Month) Day Year)

DHMH 17 Rev 06-2011

State Registrar

		4	For State Registrer	State of Ma	ryland		artment of H tificate of I		and Mental F	ygien Reg. N	2012	0382
Dhy	sicia		1. Decedent's Name (First, Middle, Last,)					2. Date ofMonth	D	ay Year	3. Time of Death
	edica	al -	Phyllis A. Crone						Febru		L, 2012	9:30 a. M
Exa	ımine	er	4a. Facility Name (If not institution, give				4b. City, Town, or		of Death	4	c. County of Dea	
			Golden Living Control of Golden Golde		(In yrs. la	st birthday)	Hagers If Under 1 Year	If Under	24 Hrs. 8. Date of	Birth	Washing 9. Bir	thplace (State or Foreign ountry)
Fune Direc			220-42-6135]M 2□ X F	66	Yrs.	Months Days	Hours	Min. (Month, 02/0	Day, Year 8/194	7 45 Ma	ryland
			Usual Residence of Decedent									1
arylar	1		10a. State 10b. County	,		Town or Lo						10d. Inside City Limits 1 ☑ Yes 2 ☐ No
he Ma		ecto	MD Frederic	CK	ľ	reder:				10- 0	itizen of What Co	Λ
with t		5	10e. Street and Number 1421 Taney Ave.	Apt 216			10f. Zip Code 217	02		1	nited St	-
leath		era	11. Marital Status	12. Was Decedent B	Ever in U.S	. 13.1	Vas Decedent of H	ispanic Ori	gin? (Specify Yes or		14. Race - Ame	erican Indian,
parifillior (e), Ivial yiallia A.I.A. 10-0000 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "natural", or Items 23a or 28a-f show	E2011 11 181	by Funeral Director	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 💢 Divorced	Armed Forces? 1 □ Yes 2 ☒N If Yes, Give Year or Dates:	lo		f Yes, specify Cuba 1 ☐ Yes 2 🛣 No	n, Mexicar Specify:	i, Puèrto Rican, etc.)		Bleck, White Specify: Wh	
72 hc	alse.	etec	15. Decedent's Edu (Specify only highest grad	cation e completed)		16a. Deced	dent's Usual Occup kind of work done o DO NOT use retired	ation during mos	t of working	16b.	Kind of Business	/Industry
dithin		Completed	Elementary/Secondary (0-12)	College (1-4or 5	+)			1)			Astol In	desa trace
Hygie ther t	ar, in	ပိ	17. Father's Name (First, Middle, Last)			House	ekeeper	18. Mothe	er's Name (First, Mid		Motel In	dustry
d be ental		To Be	Merle Crone					M	lary Haupt			
shoul nd M		-	19a. Informant's Name/Relationship (T)	/pe, Pnnt)		19b. Mailir	ng Address (Street		er or Rural Route Nu	nber, City	or Town, State,	Zip Code)
alth a			David Stine / son			19209) Longmea	dow R	Road, Hage	rstov	wn, MD 2	17 42
S 1 a			20a. Method of Disposition	Damassal fram State	20b. Pla	ace of Dispo	sition (Name of natory or other place	e)	Date	20c.	Location - City or	Town, State
Page Page	n d		1 Durial 2 Cremation 3 F 4 Donation 5 Other (Specify)			ormed	Cemetery	2	2/6/2012		ddletown	
eparti oporti	eny in		21. Signature of Funeral Service Licens	1/1	MO12	22	Name and Addre	ss of Facili	Keeney &	Basi	tord Fun	eral Home
u aoe	a	_	23a. Part1. Enter the disease, or comp.	1000					St., Fred		, IID 21	Approximate
Medi Examil	cal ner	Examiner	shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a	Sep S a conseque a conseque	pluv ence of):	nω					Interval Between Onset and Death 48 hours
ate be ex	0	dicai	•	d								
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after deeth. To the Funeral Director: After this certificate has been signed by the attending physicien and	ched for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal	death 3[Ectopic pregnancy Other (specify)	,		_	23d. Date of de Month	elivery Day Year
that i	deta	F P	Part II. Other significant conditions co	ntributing to death be	ut not resu	lting in the u	nderlying cause giv	en in Part I	. 23e. D	id tobacco	o use contribute t	to the cause of death?
w requires to been signed		ed by							1	□Yes	2 □ No 3 □ P	robably 45Unknow
The law real te has bee	age z sno	Completed							24a. W a p 1 Ye	utopsy erformed?	death?	
ician:	ctor, p	Be	25. Was case referred to medical examiner?					26. Place	e of Death (Check or			
Physic this of	e die	ဂ္	1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatie		R/Outpatier		4ij XIVI	ursing Home 5 🗆 R			ecily)
ing P	unera	on:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Inju (Month, Da)	ry y Year)	28b. Time o Injury	Wor			be how in	jury occurred	
or Attending safter deeth.	d in by the r	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injuding, etc.	ury - At hor c. (Specify	ne, farm, sti	reet, factory, office	Yes 2	28f. Locatio	n (Street Town, Sta	and Number or F ate)	Rural Route Number,
Hospita 24 hours	setely fille	Medicai C	29a. Certifier Certifying Phy (Check only one)	vsicien: To the best iner: On the basis of and manner sta	examinati	vledge, deat on and/or in	h occurred at the tir vestigation, in my d	ne, date ar pinion, dea	nd place, and due to ath occurred at the tir	the cause ne, date a	(s) and manner a and place, and du	is stated. ie to the cause(s)
Total Total	Eoo	Σ	29b. Signature and title of certifier MOW Jew	gon	aj		29c. Licens	365		29d. [Date signed (Mor	
Da.,			30. Name and address of person who c	2 8H	API	368	Print)	Je	rest He	iges	form	MD 2/74
Re	Sta gistra		31. Date filed (Month, Day, Year)	32. Registra	ar s Signat	re Kad						
115	4/00		LED I A SAIL	Known fo	1. 14							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Wilson Kenneth Davis 0545 JANUARY 2012 Medical a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner HOSPITA TIMORE AGNES 7. Age (În yrs. last birthday) 84 vrs 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 9. Birthplace (State or Foreign Funeral Month, Day, Year) OV. 03,1927 1 🕅 M 2 🗆 F Months Hours Connecticut **Director** 044-22-0184 Nov. Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits event, the Medical Examiner must be notified at Director MD Baltimore Catonsville 1 Yes 2 X No 10e. Street and Number 10f. Zip Code ŏ 10g. Citizen of What Country? 23a Funeral 715 Maiden Choice Lane Unit HV 422 21228 USA items ? hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. 1945-If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc ö þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1947 1 ☐ Yes 2 X No Specify: White "natural", 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Boy Scouts of and Mental Hygiene. is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Executive America Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental Important: If item 27 is marked c any injury or other traumatic eve ည Harold Davis Lillian Goodsell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Lane Davis / Wife 715 Maiden Choice Lane Condo HV 422 Catonsville, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State January 28 Baltimore, MD Metro Crematory, INC 4 Donation 5 Other (Specify) 2012 Rarranco & Sons, P.A. Severna Park Funeral Home 495 Ritchie Hwy, Severna Park, MD 21146 21. Signature of Funeral Service License 23 First 1. Enter the disease, or conclications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, heart failure. List obly one cause on each line.

Immedia cause (Final disease or condition ASPIRATION PNEUMONIA) Onset and Death

Onset and Death Physician/ ASPIRATION Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Other (specify) Pregnant at time of death within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the a completed filled in by the funeral director, page 2 should be detached it 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. KENNETH 23e. Did tobacco use contribute to the cause of death? Completed by MYASTHENIA GRAVIS 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an Hospital or Attending Physician; The law autopsy performed Yes 2 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No 1 🗌 Yes ပ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Investigation Accident 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 🔀 ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death d at the time, date and place, and due to the cause(s) and manner as state 29b. Signature and title 29d. Date signed (Month, Day, Year) *JANUARY* 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE JONATHAN RONGUILLD

State Registrar

the burial-

Physician

/Medical

Examiner

Director

Funeral

þ

Completed

Be မ

Funeral

Director

	rialy Elizabeth Dev	/IIII/Daughter W	asiming con, D.C. 200	710	
	20a. Method of Disposition	20b. Place of E	Disposition (Name of	Date 20c. L	ocation - City or Town, State
	1 ☑ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State Gate Cemeter	of Heaven ery Jan 20)12 Sil	ver Spring, Md.
	21. Signature of Funeral Service License	M00215	22. Name and Address of Facility	DeVol Funera	al Home
	Henry J.	For			shington, D.C.20007
caminer	23a. Part1. Enter the disease or complishock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Undersying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of	ordis voscula		Approximate Interval Between Onset and Death
Completed by Physician/Medical Examiner	IF FEMALE:	Due to (or as a constituence of Per Shared State of Per Shared State of Per Shared State of Per Shared State of Per Shared State of Per Shared State of Per Shared	3 Ectopic pregnancy 5 Other (specify)	sen -	23d. Date of delivery Month Day Year
d by Phy	Part II. Other significant conditions con		he underlying cause given in Part I.		use contribute to the cause of death?
Complete	Deep Vein The	emposs.		24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
Be	25. Was case referred to medical examiner?		26. Place of De	ath (Check only one)	
0	1 Yes 2 No	ospital: 1 ☐ Inpatient 2 ☐ ER/Outp	atient 3 DOA Other: Nursing I	Home 5 ☐ Residence	6 □Other (Specify)
ation: 1	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Tir	ne of 28c. Injury at	28d. Describe how inju	
Medical Certification: To	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At home, farm building, etc. (Specify)	n, street, factory, office	28f. Location (Street a City or Town, Stat	nd Number or Rural Route Number, e)
dical (29a. Certifier (Check only one) 12 Certifying Phys 2 Medical Examin	ician: To the best of my knowledge, oner: On the basis of examination and/and manner stated.	death occurred at the time, date and plac or investigation, in my opinion, death occ	e, and due to the cause(surred at the time, date ar	s) and manner as stated. nd place, and due to the cause(s)
Me	29b. Signature and title of certifles		29c. License number	29d. Da	ate signed (Month, Day, Year)
	1		D35579	0	1/16/2012
	30. Name and address of person who con	mpleted cause of death (Item 23a) (Ty	ype, Print) Discosin RNR #3	05, Bethe	de mo 20814
te ar	31. Date filed (Month, Day, Year) JAN 19 2012	32 Registrar's Signature	harles.	,	

State Registrar

DERZOOKIAN, AZNIV 1/17/12 0630 AM

			Please	Type or Print State of Mar				•	_	ble.	
		•	For State Registrar	Otate of Mai		tificate of E			g. No. 2	12	03832
ı	Physicia Medic		1. Decedent's Name (First, Middle, Las Azniv Derzoc				_	2. Date of Death Jan 17, 2		Year	3. Time of Death 6:30am м
	Examin	er	4a. Facility Name (if not institution, give Suburban Hospit			4b. City, Town, or Bethesd	Location of Death		4c. County o		7
	Funeral Director		218-68-331/	ex	n yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Dec 25,	(919	9. Birthp Gount	lace (State or Foreign
	Maryland :8a-f show tified at	rector	Usual Residence of Decedent		Oc. City, Town or Loc Bethesda	cation		· · · · · · · · · · · · · · · · · · ·		11	0d. Inside City Limits
	with the N is 23a or 2 nust be no	neral Di	10e. Street and Number 5101 River Rd #90)9		10f. Zip Code 20816			og. Citizen of Wh J nited S		*
9800	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Eve Armed Forces? 1 Yes 2 X No If Yes, Give Year or Dates.	. 11	Vas Decedent of Hi f Yes, specify Cubar ☐ Yes 2 🛣 No	n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race Black, Specify: V	White e	etc.
21215-0036	vithin 72 hou liene. er than "natu the Medica		15. Decedent's E (Specify only highest gra Elementary/Seconday (0-12)		(Give F	lent's Usual Occupa kind of work done d O NOT use retired) emaker	ation uring most of work	ing 1	16b. Kind of Bus	iness Ind	lustry
Maryland 2	ild be filed v Mental Hyg narked othe latic event,	To Be	17. Father's Name (First, Middle, Last) Khachik Grigoria					e (First, Middle, Ma eth Grigo			
, Mar	d 2 shou ealth and n 27 is m er traum		19a. Informant's Name/Relationship (T		19b. Mailin 6010	g Address (Street a Greentre	e Rd, Be	al Route Number, C thesda, N	City or Town, Sta MD 20817	ite, Zip C 7	Code)
Baltimore,	Page 1 an nent of He ant: If iten ury or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special		Parklawn	natory or other place Mem Park	1-20	-2012	Rockvi	lle,	MD
Balt	permit. Page 'Department or Important: If any injury or once.		21. Signature of Funeral Service Licens		22	Name and Addres	onsin Av	seph Gawl e, N.W. V	ler's So Washingt	ons I	DC 20016
	Pnysician/ Medical	g 5	23a. Part 1. Enter the disease, or com shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	alications that caused the cause on each line. a		er the mode of dying	g, such as cardiac (or respiratory arres	t,	1	Approximate Interval Between Onset and Death
	Examiner	Je.	Sequentially list conditions,	b. hypo	tension						
-	be executed sician and burial-transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last	C. Due to (or as a co							
09289	cate be e physicial the buri	edical		d							
. Box 68	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Completed by Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼ No 9 □ Unknown	23c. If yes, outcome of 1 Live Birth 2 4 Pregnant at til 9 Unknown	Fetal death 3	Ectopic pregnanc Other (specify)	у		23d. Date Mont		ery Day Year
ls, P.O.	uires that the dea n signed by the a ıld be detached f	ed by Pi	Part II. Other significant conditions c	ontributing to death but	not resulting in the u	nderlying cause giv	en in Part I.				e cause of death?
Division of Vital Records,	fhe law require ate has been si bage 2 should I	omplet						24a. Was an autopsy perform	/ pri	ior to cor ath?	psy findings available impletion of cause of
/ital	sician; certifica irector, p	Be	25. Was case referred to medical examiner? X 1 No	Hospital:	2 ☐ ER/Outpatien		ace of Death (Chec	k only one)			
on of V	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: Atter this certificate has completed filled in by the funeral director, page 2.	Certificate: To	27. Manner of Death 1 X Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day, Y	28b. Time of	28c. Injury work	4 □ Nursing Ho	ome 5 Resider 28d. Describe how			
Division	tal or Atters after de al Directo	al Certif	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of Injury building, etc. (\$	- At home, farm, stre Specify)	eet, factory, office		28f. Location (Stre City or Town,		or Rural	Route Number,
	ne Hospi In 24 hou ne Funer pleted fill	Medical	(Check 2 Medical Exam	sician: To the best of my ner: On the basis of exar se Practioner: To the bes	nination and/or invest	igation, in my opinio	n, death occurred a	the time, date and	place, and due t	to the cau	use(s) and manner stated.
	To with with Education	-7.	29b. Signature and title of certifier	~ Clu	N	29c. License	number +499	29	od. Date signed (
	•		30. Name and address of person who contistine J.	completed cause of deat Castro, M.D	th (Item 23a) (Type, F 8600 01	rint)		Behtesda	, MD 20	814	
	Sta Registr		31. Date filed (Month, Day, Year) JAN 19 201	2 Registrar's	Signature	ALB.					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ Month Year Alfred Dunlap 2012 3:45 p Jan. 14 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Manor Care Health Systems Wheaton Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, May 23, 9. Birthplace (State or Foreign **Funeral** 7. Age (In yrs. last birthday) Days 1 X M 2 🗆 F Months Hours Min Kansas **Director** 579-07-5857 97 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director DC Washington 1X Yes 2 No items 23a or ner must be n 9 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 719 Shepherd Street, N.W. 20011 United States death 12. Was Decedent Ever in U.S. Armed Forces?

1 🛎 Yes 2 🗆 No If Yes, Give 1941— Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc.
African-"natural", or 1 Never Married 2 Married ş 1941<u>-</u> Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify. oe fied with...
Mental Hygiene.
*d other than "natu..
*t the Medical E? Completed 3 Widowed 4 Divorced Year or Dates. American 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Chemical Engineer Federal Government traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental Fire is marked of ပ Balis Allen Dunlap Bessie Lee Dunlap 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dolly Sparkman-Daughter 1 and 2 s of Health item 27 1304 Erskine STreet, Takoma Park, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1. Department of Important; If it any injury or or 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln 1/21/2012 Brentwood, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility McGuire Funeral Service, Inc. 1m 7400 Georgia Ave., N.W. Washington, D.C. 20012 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Ph_sician/ disease or condition resulting in death) Congestive Heart Failure Years Medical Due to (or as a consequence of) Examiner Dilated Cardiomyopathy Years Sequentially list conditions, if any, leading to immediate cause. Enter underlying Due to (or as a consequence of) Exami Cause (Disease or iinjury and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical The law requires that the death certificate be Box 68760 IE FEMALE yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) Live Birth 2 Fetal death in the past 12 months? Pregnant at time of death Month Dav Year 2 No the detached P.O. ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Hypertension Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗷 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy nerformed certificate 1 Yes 2 XNo Yes 2 X No To the Hospital or Attending Physician:
within 24 hours after death.
To the Funeral Director: After this certific.
Completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 X No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4x Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Deatl 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury X Natural 5 Pending 1 🗌 Yes 2 🗌 No Accider
Suicide Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

6 State

Registrar

29b. Signature and title of certifier

UNZIN

31. Date filed (Month, Day, Year)

JAN 2 6 2012

Lya Mall Karm, M.D.

2100 Pennsylvania Ave., N.W.

2

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

D33815

29d. Date signed (Month. Day, Year)

January 24, 2012

20037

Wash., D.C.

12-00874 Teresa Marie Definis Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

20	112	03	8	3	L
Sec. 14	, ı	0	-	_	

		1- For State Registrar			Certifica	ate of	Death					eg. No.			
Physicia		1. Decedent's Name (First, Middl	Month Day Year										3. Time of Death		
^odical Examii		Teresa	Marie		Defin	is					January 2	9, 2012			2018 hrs
		4a. Facility Name (if not institution	n, give street and n	umber)		4	o. City, To		ocation o	f Death			ounty of		
		Holy Cross Hospital					Silver	Spring					ntgom		
Funeral		5. Social Security Number	6. Sex	7. Age (In	n yrs. last birt	hday)	If Under		if Under				1	Birth Foreign	place (State or
Director	١	220-15-1030	1 M 2 X F		33	Yrs.	Months	Days	Hours	Min.	6/23	/197	8		ntry) MD
	ŀ	Usual Residence of Decedent													
any	ı	10a, State 10b, County		100	c. City, Town	or Locatio	n								10d. Inside City Limits
. .		MD Mont	gomery		Silv	er S	pri:	ng							1 Yes 2 X No
Aaryland 28a-f show 1 at once.	흱	10e. Street and Number					10f. Zip (Code				l0g. Citizen	of Wha	t Count	ry?
or 28	Director	1511 Harding	Lane				•	2090)5			Т	JSA		
215-0036 be filed within 72 hours after death with the Maryland ntal Hygiene. rked other than "natural", or items 23a or 28a-f sho ent, the Medical Examiner must be notified at once.			12. Was De			142.14/25				in2 / Spor	cify Yes or N			Americ	an Indian, Black,
th w	uneral	11. Marital Status 1 X Never Married 2 M	arried Armed F		ai III U.S.						ican, etc.)		White,		an indian, Diasin,
r dea	ᇎ		1 Yes	2 X	No		Yes 2	. No				9.0	ecify:	Wh	ite
ra fi	2		or Dates:		40d\ 160	Decedent				ind of wo	rk done	16b. Kind		ness/In	dustry
hour Exan	8	15. Decedent's Education (Spe				during mo						TOD. RIN	2 01 0001	110007111	doony
n 72 ical	ompleted	Elementary/Secondary (0-12)	College	(1-4 or 5+)		Hon	emal	ker)wn	Но	me
0036 within iene. Medic	틹	17. Father's Name (First, Middle	1					[10	Mothor	e Namo (irst, Middle,				
Hyge	ပ	Michael J.De						"		,					ļ
21215-0036 uld be filed within 72 hours after Mental Hygiene. marked other than "natural". c event, the Medical Examiner	Be	19a. Informant's Name/Relations			10	h Mailing	Address	(Street			Ann S			State	Zin Code)
MD 21 d 2 should lth and Me 127 is ma	유	Michael J.De		a + h a :	100	_									
MD and 2 sho salth and 2 sho raumati	H	20a. Method of Disposition	TIHITS/F	athe.	20b. Place	of Disposit	Ha]	CQ1.D	etery.	ane	SILVE Date	20c. Loc	ation - (City or T	Md 20905 Town, State
S 1 a of He t		1 Burial 2 X Cremation	n 3 Removal	from State		on or oth	er nlace)		- '			ı			
Page nent ant:		4 Donation 5 Other S	pecify:		Ches										le,Md
Baltimore, MD 21215-003 permit. Pages I and 2 should be filed withit Department of Health and Mental Hygiene. Important: If item 27 is marked other tinjury or other traumatic event, the Med		21. Signatur of Funeral Service	ensee			22 H	TLT	ddress o	ŔĨŊ	ALDI	FUNI	ERAL	RAL SERVICE, P		CE.P.A.
6 8 9 1 1 1	j	Willy ()	gerlfer			92	241	Colu	ımbi	.a B	lvd.S	ilve	r S	pri	na Ma2091
Physician		23a. Part 1. Enter the disease, or	nter#ne disease, or complications that caused the death. Do not enter the mode or dying, such as caldiac or respiratory affect, s ist only one cause on each line.									rest, shock	or hear	ŧ	oxima e Interval Between Onset and
Medical	- 0	Immediate Cause (Final disease	(Final disease a. Heroin and alcohol intoxication												Death
Examiner		or condition resulting in death)	Due to (or as						PERSONAL PROPERTY.						
	.	Sequentially list conditions,	b											_	
	릴	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as	a consequ	ence of):										
	E	(Disease or injury that initiated events resulting in death) Last	Due to (or as	a consequ	ence of):							-			
and diffe	Exa	Training in account, account	ď.												
ă gi	/Medical	X UNPENDED	AMENDED	23a,	27,28a	-f,pe	r me	,g92	4 2-	15-1	2 sm				
760, ficate be ex physician the burial	9	IF FEMALE:	23c, If yes	, outcome o	of pregnancy							23d. [ate of d	lelivery	
100		23b. Was decedent pregnant in the past 12 months?	he 1 Live	birth		E Fet	al death	3	Ectopic	pregnan	СУ	Me	onth	D	ay Year
Box 68 c death certification at the attending and for use as	Physician	1 Yes 2 No 9 V Un	L	nant at tim	e of death	5 Oth	er (Spec	fy)							la de la decembra de la decembra de la decembra de la decembra de la decembra de la decembra de la decembra de
BO)	Jy S		a Olik												
P.O.		Part II. Other significant condit	tions contributing	to death bu	ut not resultin	g in the u	nderlying	cause giv	en in Pa	rt I.					he cause of death?
	d by										1 Y	s 2 N			
requi	Completed										24a. Was				opsy findings available ompletion of cause of
co e law e has	E										perf	ormed?	de	eath?	
ian: The certificate ector, page	ပိ	OF Minary and the modice					2	6 Place	of Death	(Check or		2110	' [V 16.	, 2 110
ician: certifi rector,	Be	25. Was case referred to medica examiner?	Hospital:	Innationt	2 FR/0	utantiont				_	Home 5	Residenc	e 6	Other:	
of Vital Records, ng Physician: The law require. When this certificate has been some ineral director, page 2 should the page 2 should the page 2 should the page 2 should the page 2 should the page 2 should the page 2 should the page 2 should the page 2 should the page 2 should the page 2 should the page 2 should the page 2 should the page 2 should the page 2 should the page 2 should the page 2 should the page 3 should the	P	1 Yes 2 No 27. Manner of Death		e of Injury		Time of Ir			at Work		8d. Describe			_	
	등	1 Natural 5 Pen	(Mon	th, Day,Year) [205.	11110 01 11	,,.,,		es 2 🕱	- 1	unknov				
the state of	ä		estigation Id I	-29-		7:02					Of Location	(Street and	Number	or Rur	al Route Number, City
Division pital or Attendi ours after death. teral Director: /	Ĕ		ld not be		y - At home, fo		t, ractory,	office bu	ilidirig, et		or Town,	State) 50	4 Ea	st	Randolph Rd
Di Hospital 24 hours Funeral etcly filled	Certification:	4 Homicide	1,-,,		estaur				_		<u>Silver</u>				
Divi	_	(Citeditions)	Physician: To the basis	est of my ki	nowledge, de ation and/or	ath occur	ed at the on, in my	time, dat opinion	e and pla death oc	ice, and d curred at	iue to the cau the time, date	ise(s) and r e and place	nanner a , and du	as state le to the	u. cause(s)
To the within To the comple	Medica		and manner					License							oth, Day, Year)
	2	29b. Signature and title of certifi	1 //	The same			290						ary 30,		
		Men B	nound.	1110				O.C.N	1.⊑.			Janua	.ıy J∪,	2012	
		30. Name and address of person				000.11	5 1			- 14:	ND O46				
	Melissa Brassell, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223														
	tate	31. Date filed (Month, Day, Year)	2012 32	Registrar's	Signature	par	20								
Regis	liar	LED	LUIL WE	num	10.	7									

06₩E

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 Robert Ronald Evans 10:15 P.M January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's 6016 Martin L. King, Jr. Hwy.#103 Seat Pleasant 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🛛 M 2 🗆 F Days Hours Min (Month, Day, Year, Director 09/09/1940 577-54-1719 Wash D.C Usual Residence of Decedent be filed within r2 II-LIL II-LIL II-LIL II-LIL II-LIL III-LIL 0a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Seat Pleasant ¹X Yes 2 ☐ No Md. Prince George's 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number Funeral 6016 Martin Luther King, Jr. Hwy. U.S.A. 20743 vas Decedenti rmed Forces? X Yes 2 \ No Vas Give 1960 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 Specify: Black If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: 3 Divorced 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) 12th College (1-4 or 5+) Safeway Food Stores Merchandiser Be 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event once. 17. Father's Name (First, Middle, Last) ည Ozelle Pixley Noble Evans 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5708 Camp Springs Ave., Temple Hills, Maryland20748 Doris Jeanette Moody/Daughter 20a. Method of Disposition

Y Burial 2 □ Cremation 3 □ Removal from State 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) 02/03/12 Cheltenham, Maryland Maryland Veterans Cem! 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Henry S. Washington & Sons Co., Inc. any 4925 Burroughs Avé., N.E., Washington, D.C 20019 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions Examine cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last attending physician and I for use as the burial-transit Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day 5 Other (specify) cate has been signed by the a page 2 should be detached to 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by 1 Tes 2 No 3 Probably 4 Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy Yes 2 this certificate Division of Vital or Attending Physician: after death. filled in by the funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) Hospital: 2 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Director: After injury 1 🔀 Natural 5 Pending 2 🗌 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) To the Hospital within 24 hours a To the Funeral E Medical X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 only one 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) inpleted cause of death (Item 23a) (Type, Print) VK

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

State Registrar Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend #1 Per Phy &19a Per INF C948 2/04/2014 IH
State of Maryland Department of Health and Mental Hygiene

		1	For State Registrar		Cer	tificate of l	Death	R	eg. No. 20	2 03836		
	Physicia	n/	1. Decedent's Name (First, Middle, Last) Humberto Gregorio Hunberte	Feeudoro				2. Date of Deatl Month January	Day Year	3. Time of Death 11:40 AM		
	Medic Examin		4a. Facility Name (if not institution, give stre			4b. City. Town. o	r Location of Death	January	4c. County of Dear	1		
	Examin	CI	Washington Adventi			Takoma I			Montgome			
	Funeral Director		5. Social Security Number 6. Sex	7. Age (In yrs. las	t birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Apr 4,	9. Bir 1 92 2 E1	thplace (State or Foreign untry) Salvador		
	nd tr	١	Usual Residence of Decedent 10a. State 10b. County	10c. City.	Town or Loc	ation				10d. Inside City Limits		
	arylar a-fsk fied a	ecto	MD Prince Ge		attsvi					1 X Yes 2 □ No		
	the M or 28	١	10e. Street and Number			10f. Zip Code		1	0g. Citizen of What Co	ountry?		
	h with	Funeral Director	2526 Avalon Place				20783		USA			
036	should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show is marked other than "natural".	by	11. Marital Status 12 1 Never Married 2 Amarried 3 Widowed 4 Divorced	Nas Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates.			dispanic Origin? (Span, Mexican, Puerto Specify:E1 S		n 14. Race - Ame Black, Whit Specify: L			
ე- ე-	2 hou "natu edical	plet	15. Decedent's Educ (Specify only highest grade		(Give k		during most of work	ring	16b. Kind of Business			
121	ithin 7 ene. than he Me	Completed	Elementary/Seconday (0-12)	College (1-4 or 5+)		O NOT use retired) r Large	Equipment	.	Department Agricult			
Q Q	led wi Hygie other ent, t	on h	17. Father's Name (First, Middle, Last)		DIIVO	Luige	18. Mother's Nam			320		
/Jan	d be fi Mental arked ttic ev	ပ	Jose Escudero				Ortensi	Penate				
Baltimore, Maryland 21215-0036	of Health and Ment of Health and Ment fitem 27 is marked rother traumatic		19a. Informant's Name/Relationship (Type, Ana Hilda Escude Ana H. Escudere	Print) ro-wife life					City or Town, State, Zi			
ore,	Page 1 an nent of He ant: If iten ury or othe		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re	moval from State Cel	metery, crem	sition (Name of natory or other pla	ce)		20c. Location - City or			
Ħ	permit. Page Department of Important: If any injury or once.		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee	Metr		. Name and Addre	tory 1/28	/2012 A.	lexandria, 4739 Balt:			
Ba	Dep Imp any			Any Posers				ne, P.A.	Hyattsvil:	Le, MD 20781		
	×		23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one of		Do not ente	r the mode of dyir	ng, such as cardiac	or respiratory arre	st,	Approximate Interval Between		
-1	h ician Medical		Immediate Cause (Final disease or condition resulting in death)	Thrombocytor						Onset and Death		
	Examiner		resulting in deathy	Due to (or as a conseque Esophageal (10 years		
	PERSONAL PROPERTY.	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a conseque						<u> </u>		
	ificate be executed ig physician and as the burial-transit	Examiner	Cause (Disease or iinjury that initiated events c. resulting in death) Last	Due to (or as a conseque	ence of):							
0	be ex sician burial	Medical	d	,								
8760	ficate g phy as the	Medi	_ v.									
Box 6	death cert ne attendir ed for use	Physician/	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	c. If yes, outcome of pregnand 1 Live Birth 2 Fetal 4 Pregnant at time of de 9 Unknown	death 3 🗆	Ectopic pregnan Other (specify)	су		23d. Date of de Month	elivery Day Year		
P.O.	that th ned by e detac	by Ph	Part II. Other significant conditions contr	buting to death but not resul	Iting in the u	nderlying cause g	iven in Part I.	23e. Did tob	pacco use contribute to	the cause of death?		
ds,	quires en sign ould be							1 □ Y€	es 2 🗆 No 3 🛣 F	Probably 4 🗆 Unknown		
3ecor	sician: The law requires that the certificate has been signed by the lirector, page 2 should be detach	Completed						24a. Was ar autops perforr 1 \(\sum \) Yes	med? prior to death?	utopsy findings available completion of cause of		
g	ysician; 1 is certifica director, p	Be	25. Was case referred to medical examiner?				lace of Death (Chec					
\equiv	Physic this of	၉	1 ☐ Yes 2 ☒ No Ho:	spital:	R/Outpatier		4 □ Nursing H		ence 6 Other (Spec	cify)		
0 0	ding h. After funer	cate	1 X Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day, Year)	injury	28c, Injui wor M 1 -		28d. Describe no	w injury occurred			
Division of Vital Records,	pital or Atten ours after deat eral Director; filled in by the	Certificate:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	ne, farm, stre			28f. Location (Str City or Town	reet and Number or Ru , State)	ural Route Number,		
-	To the Hospital or A within 24 hours after To the Funeral Direct completed filled in by	Medical	(Check 2 Medical Examine)	an: To the best of my knowle : On the basis of examination Practioner: To the best of my	and/or invest	igation, in my opini	ion, death occurred a	at the time, date an	d place, and due to the	cause(s) and manner stated.		
	Vithir To the	2	29b. Signature and title of certifier		NO	29c. Licens			9d. Date signed (Mont	h, Day, Year)		
9			30. Name and address of person who com				1772		1-24-2	-0/		
R	_ 2		Cecile Silvertr	e 7600 Car	roll A		oma Park,	MD 2091	2			
	Sta Registra		31. Date filed (Month, Day, Year) JAN 3 0 2012	32. Regiotrar's Signatu	re							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 03837 State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 8:29 pM Thomas Leo Ford Medical 4a. Facility Name (if not institution, give street and number) 4b. City Town, or Location of Death 4c. County of Death **Examiner** Prince Georges Forestville MD 7161 Cross St. Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Year) Days Hours Director 215-46-1131 1 🕱 M 2 🗆 F Maryland 64 1/7/47 Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10d Inside City Limits 10a. State 10c. City. Town or Location Director MD Forestville 1 Yes 2 No Prince Georges 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20747 7161 Cross Street USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc 1 Never Married 2 Married þ hours after Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) should be filed within 7 and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Labor Private Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be Department of Health and Mente Important: If item 27 is marked a marked a markey or other traumatic events. ပ Nellie Henson Leo Ford 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20747 7161 Cross St. Forestville, MD Denise Mercer-Ford, wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1X Burial 2 Cremation 3 Removal from State 1/14/2012 Suitland, MD Lincoln Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lieensee 22. Name and Address of Facility Latney's Funeral Home, 3831 Georgia Ave. NW Washington, DC cc278 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure List only one cause on each line. Onset and Death
Months Immediate Cause (Final Physician/ Pancreatic Carcinoma disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, Due to for as a consequence of if any, leading to mimediate cause. Enter Underlying Cause (Disease or injury that initiated events requires that the death certificate be executed sician and burial-tran Due to (or as a consequence of): resulting in death) Last physician sthe burial Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Day Year Pregnant at time of death 1 Yes 2 9 Unknown 2 No the g Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has Hospital or Attending Physician: The law autopsy page performed? death? certificate 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 1 Yes 2 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: fter X Natural 5 Pending injury death. 1 Yes 2 No 2 Accident
3 Suicide Investigation irector: the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by fter 4 Homicide determined City or Town, State) within 24 hours of To the Funeral Di completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number te 1/13/2012 D43346

DHMH 17 Rev 06-2011

State

Registrar

8926 Woodyard Rd.

#201

Clinton, MD

20735

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Gupta, MD

JAN 19 2012

31. Date filed (Month, Day, Year)

Rita

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death RegistraMEND#19boerFH, 1/27/2012, BMW, McCo Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 25, 1:30 a M January R. Ann Fletcher Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Hospice-Casey House Rockville Montgomery 5. Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours Mir (Month, Day, Year) Director 579-48-1361 1 □ M 2 🔼 F Yrs 79 June 4, 1932 Washington, DC Usual Residence of Decedent or 28a-f show notified at death with the Maryland 10a. State 10b. County 10c. City. Town or Location Director 1 Yes 2 No MD Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō items 23a or ner must be r Funeral 20901 115 Lexington Drive USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status "natural", or iter Yes, specify Cuban, Mexican, Puerto Rican, etc. Armed Forces? Black, White, et Specify: White , or þ 1 Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examin any injury or other traumatic and 1 Yes 2 No Specify: If Yes, Give Year or Dates 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Own Home 12 Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ္ John Anderson Margaret Unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
115 Lexington Driev, Silver Spring, MD 209 19a. Informant's Name/Relationship (Type, Print) Michael W. Fletcher/Son Silver Spring, MD 20901 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Jan 28, cemetery, crematory or other place) 1 XBurial 2 Cremation 3 Removal from State Lakemont Memorial 4 Donation 5 Other (Specify) Davidsonville, MD 22. Name and Address of Facilit Francis J. Coll 500 University Signal ure of Juneral Service Licensee ins Funeral Home Blvd. W., Silver Spring, MD 20901 Tichard I Sates Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Septicemia disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last the burial physician Physician/Medical use as attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Year Month Day Pregnant at time of death signed by the at be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ C. Difficile Colitis, Congestive Heart Failure 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performe Yes 2 🔀 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospice Hospital 2 🔀 No 1 🗌 Yes ျ funeral

To the Hospital or Attending Physician: The law requires that the death certificate be executed P.O. Box 68760 Division of Vital Records, within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

Baltimore, Maryland 21215-0036

Other: 4 Nursing Home 5 Residence 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 X Natural 5 Pending 2 🗆 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number R143201 25 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Debrah Miller, CRNP 3110 Gracefield Road, Silver Spring, MD 20904 31. Date filed (Month, Day, Year) Registrar's Signature JAN 26 2012

State Registrar

Certificate:

Medical

			State of Maryland / D	epartment of F Certificate of L		1ental Hyg	giene 2 (012 03839
			Registrar 1. Decedent's Name (First, Middle, Last)	Certificate of L	Jeath	2. Date of Dea	Reg. No.	3. Time of Death
	Physicia	n/	Marsha D. Guzzey			Month January		012 4:17 p M
	Medic Examin		4a. Facility Name (if not institution, give street and number)	4b. Citv. Town, or	Location of Death	Dandary	4c. County	
	EXAMILIT	er	Holy Cross Hospital	Silver			Montg	
	Funeral	4	5. Social Security Number 6. Sex 7. Age (In yrs. last birthe	day) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	Year)	Birthplace (State or Foreign Country)
	Director			rs.		Oct 14		DC
pu	how	5	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town	or Location				10d. Inside City Limits
Aaryla	8a-fs tified	ect	MD Montgomery Silver	Spring				1 ☐ Yes 2 🔀 No
the	a or 2 be no	Ö	10e. Street and Number	10f. Zip Code			10g. Citizen of	What Country?
h with	ns 23	Funeral Director	12107 Dewey Road	20906			USA	
deat	r iten iner r		11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 ☑ Married 1 □ Yes 2 ☑ No	13. Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Spe an, Mexican, Puerto	cify Yes or No- Rican, etc.)		ce - American Indian, ck, White, etc.
036 s after	al", o Exam	d by	1 □ Never Married 2 ★ Married 1 □ Yes 2 ★ No If Yes, Give Year or Dates.	1 ☐ Yes 2 🔀 No	Specify:		Specify	White
D-C	natur	olete	15. Decedent's Education 16a. I	Decedent's Usual Occup Give kind of work done of	ation	ina	16b. Kind of B	susiness/Industry
21 :	he. than " e Me	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	life. DO NOT use retired)		, ig	Coft.	re Company
d with	ther th	Be C	12 2 0: 17. Father's Name (<i>First, Middle, Last</i>)	ffice Manag	18. Mother's Name	(Eirst Middle		
and be file	of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	To	William T. Denekas		Helen St		vialderi Gurriarri	6)
Juo r	nd Me s mar umati			Mailing Address (Street	and Number or Rura	al Route Number	; City or Town, S	State, Zip Code)
Z 28	altha 127ie ertra		Kathryn M. D. Guzzey/Daughter 12	107 Dewey R	oad Silve	r Sprin	g, MD 2	.0906
ore e 1 ar	of He If iten or oth		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 20b. Place of cemetery	Disposition (Name of , crematory or other place	ce)	Date	20c. Location	- City or Town, State
tim Pag	tment tant: jury c		4 Donation 5 Other (Specify) Metrop	olitan Crem				ria, Virginia
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after	Department of h Important: If ite any injury or ot		21. Signature of Funeral Service Licensee	nc. Spring ,MD 20901				
			23a. Part 1. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line.	ot enter the mode of dyir	g, such as cardiac	or respiratory arr	est,	Approximate Interval Between
	sician/	0.3	Immediate Cause (Final disease or condition Anoxic Encephal					Onset and Death
	Medical xaminer		Due to (or as a consequence of					
		ler	Sequentially list conditions if any, leading to immediate Cardiopulmonary Due to (or as a consequence of					
ted	dansit	Examiner	cause. Enter Underlying Cause (Disease or injury Sepsis					
exect	an an irial-tr	EX	that initiated events resulting in death) Last Due to (or as a consequence of	•				
60 rte be	been signed by the attending physician and should be detached for use as the burial-transit	dical	Aspiration Pneu	monia				
687 ertifice	ding p se as	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy				22d D	ate of delivery
. Box I	attene For us	Physician/Me	23b. Was decedent pregnant in the past 12 points? 1 Yes 2 No 1 Yes 2 No 1 Yes	3 ☐ Ectopic pregnand 5 ☐ Other (specify) _	cy .			onth Day Year
. B	by the ached	hysi	9 Unknown					
P.O.	gned k	by P	Part II. Other significant conditions contributing to death but not resulting in	the underlying cause gi	ven in Part I.			tribute to the cause of death?
ds,	en sié	ted	End-Stage Liver Disease			1 📙		3 ☐ Probably 4 🖾 Unknown
law re	has be e 2 sh	Completed by				24a. Was	osy	Were autopsy findings available prior to completion of cause of death?
8 = 1	icate r, pag		25. Was case referred to medical			perfo 1 ☐ Yes	2 No	1 Yes 2 No
/ita siciar	certif	Be c	25. Was case referred to friedical examiner? 1 □ Yes 2 ☒ No Hospital: 1 ☒ Inpatient 2 □ ER/Out		lace of Death (Chec.		dance of Oth	ner (Canaita)
of v	er this neral o	e: To	27. Manner of Death 28a. Date of injury 28b. Ti	ime of 28c. Injur	y at	28d. Describe h		
On endin	eath. or: Afte he fur	ficat	2 Accident Investigation		Yes 2 No			
Division of Vital Records, tal or Attending Physician: The law requires	ifter de Directo in by t	Certificate:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm building, etc. (Specify)	m, street, factory, office		28f. Location (S City or Tow		per or Rural Route Number,
Spital	within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and To make the funeral director, page 2 should be detached for use as the burial-transi Completely filled in by the funeral director, page 2 should be detached for use as the burial-transi	edical (29a. Certifier 1 X Certifying Physician: To the best of my knowledge, d	leath occurred at the tim	e, date and place, a	nd due to the ca	ause(s) and man	ner as stated.
e Hos	in 24 ł ne Fur pletely	Medi	(Check only one) 2 Medical Examiner: On the basis of examination and/or and/or only one) 3 Certifying Nurse Practitioner: To the best of my know	investigation, in my opini	on, death occurred a	t the time, date a	nd place, and du	ue to the cause(s) and manner stated.
To #		-	29b. Signature and title of certifier	29c. Licens				ed (Month, Day, Year)
	12		> f flahman		66372		January	7 17, 2012
			30. Name and address of person who completed cause of death (Item 23a) (Tomatian Rahmanian, MD 1500 Fores	ype, Print) t Glen Road,	Silver S	Spring,	MD 2091	.0
	Sta Registra		31. Date filed (Month, Day, Year) JAN 1 9 2012 2. Registrar's Signature	hares.				

		1	For State Registrar	State of Ma	iryland /	•	rtment of H			giene Reg. No.	2012	03840
			Decedent's Name (First, Middle, La.)	st)					2. Date of De Month	ath Day	y Ye ar	3. Time of Death
	Physicia Medic	al	Mary Jane Grov	ær					Jan.		6. 2012	6:10 а.м
	Examin		4a. Facility Name (if not institution, give	street and number)			4b. City, Town, or I	Location of Death		4c.	. County of Death	n
فمرر			10712 Alloway 3		(In yrs. last bir	th day)	Potomac If Under 1 Year	C If Under 24 Hrs.	8. Date of Bir		Montgome	hplace (State or Foreign
	Funeral Director		577-20-9188	M 2 FFE	90		Months Days	Hours Min.	(Month, Da May 19	y, Year)	Cou	ington, D.C.
pue	show	tor	Usual Residence of Decedent 10a. State 10b. County		10c. City, Tow	n or Loca	ation					10d. Inside City Limits
Mary	28a-1 otifie	Funeral Director	Md. Montgon	ery	Potor	mac						1 X Yes 2 No
the the	a or be n	a D	10e. Street and Number				10f. Zip Code			10g. Cit	tizen of What Co	untry?
th wi	ns 23 must	iner		y Drive		40.34	20854		soifu Vas ex No		U.S.A	
356 after deal	ger and a should be incomment and the should be a should be many and to the show the should be s	þ	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Was Decedent Evaluation Armed Forces? 1 Yes 2 If Yes, Give Year or Dates.		If	as Decedent of His Yes, specify Cuban Yes 2 X No	, Mexican, Puerto	echy fes of No- Rican, etc.)		14. Race - Amer Black, White Specify: Wh:	, etc.
Maryland 21215-0036	"natura edical E	Completed	15. Decedent's 8 (Specify only highest g	ducation	16a	(Give ki	ent's Usual Occupa and of work done du	tion uring most of work	king	16b. K	ind of Business I	Industry
121 7 dift	than	S	Elementary/Seconday (0-12)	College (1-4 or 5-			NOT use retired)	cretary		11.9	S. Navy	League
א פ	Hygie other ent, t	Be (17. Father's Name (First, Middle, Last)		1 15.	Aecu	CIVE BEC	18. Mother's Nan	ne (First, Middle,	-		<u> Louguo</u>
a g	ental ked ic ev	၉	William J. Coll	ins				Cather	ine V.	Shea	han	
ary ary	nd M s mar		19a. Informant's Name/Relationship (19	b. Mailing	Address (Street at 2 Allowa					Code)
Ž Š	alth a alth a 1.27 is er tra		Frances Reyes/S	ister		Pot o	2 Alloway mac <u>, Mar</u>	y Drive yland 2	0854			
Baltimore,	ayer and ent of He nt; If iten ry or oth		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec	Removal from State	20b. Place of cemeter Met	of Dispos ery, crem TODO	ition (Name of atory or other place litan ry) Jan 20	Date 20,		ocation - City or xandria.	
Baltii	Department of Important; If any injury or once.		21. Signature of Funeral Service Liger			22.	Name and Address	s of Facility De	eVol Fu	neral	1 Home	
		Н	23a. Part 1. Enter the disease, or con shock, or heart failure. List only	pplications that caused	the death. Do						shington	Approximate Interval Between
P	n sician/ Medical	, N	Immediate Cause (Final disease or condition resulting in death)		tive He	eart	Failure					Onset and Death 6 Months
E	xaminer				ic Card	,	tonathy					5 Years
		Je.	Sequentially list conditions, in any, leading to immediate cause. Enter Underlying	b. Due to (bras a			ropachy					
ted	ausit o	Examiner	cause. Enter Underlying Cause (Disease or iinjury that initiated events	c ————				_		_		
exect	an an rial		resulting in death) Last	Due to (or as a	consequence	of):					1	
94e be	physician and sthe burial transit	edical		d								
Records, P.O. Box 68760 The law requires that the death certificate be executed.	the attending principle for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	23c. If yes, outcome of Live Birth 1 Pregnant at 9 Unknown	2 🗌 Fetal dea		Ectopic pregnancy Other (specify)	4			23d. Date of del Month	iivery Day Year
O.H. that the	been signed by the should be detached	by	Part II. Other significant conditions	_	ut not resulting	in the ur	nderlying cause give	en in Part I.				the cause of death?
ds,	sen si ould t	ted	Severe Aortic	Stenosis								robably 4 Unknown
Division of Vital Records, P.O.	certificate has bi	Completed							24a. Was auto perfi 1 Yes	psy ormed?	prior to death?	topsy findings available completion of cause of
<u>a</u>	ertific ector,	Be (25. Was case referred to medical examiner?	Hospital:				ce of Death (Che	ck only one)			
Y Shysi	this c	욘	1 ☐ Yes 2 🔀 No 27. Manner of Death	1 Inpatie	ent 2 ER/C	Outpatien		4 U Nursing H			6 ☐ Other (Spec	ify)
001	h. After funer	ate	1 X Natural 5 Pending	(Month, Day		injury	28c. Injury work M 1 🗆		28d. Describe	now injur	y occurred	
Sio	r deat cctor: by the	Certificate:	2 Accident Investigation 3 Suicide 6 Could not 4 Homicide determined	28e. Place of Inju	ry - At home, f	farm, stre		100 2 2 110				ral Route Number,
	s afte		4 - Nothicide determined	building, etc	. (Specify)				City or To	wn, State		
Hoenit	within 24 hours after death. To the Funeral Director: After this certificate completed filled in by the funeral director, pa	ledical	(Check 2 - Medical Exar	ysician: To the best of onliner: On the basis of express Practioner: To the l	kamination and/	or investi	gation, in my opinio	n, death occurred	at the time, date	and place	e, and due to the	cause(s) and manner stated.
To #	within To the Comp	Σ	29b. Signature and title of certifier		, , , , , , , , , , , , , , , , , , , ,	-3-1	29c. License				ate signed (Month	
			> Home				D205	35		Jan	uary 17	, 2012
			30. Name and address of person who	completed cause of de	eath (Item 23a)	(Type, P	rint)					
			Roger Stevenson		6410	Roc	kledge D	rive, Su	ite 200	, Ве	thesda,	Md. 20817
	Sta Registr		31. Date filed (Month, Day, Year) JAN 19 20	12 Central	r's Signature	far	ped)					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 9:25.A. M Wayne B. Gullatt 25,2012 January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Cheverly Prince George's Hospital Center Prince George's Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number Funeral Days Phila., Pa. Hours 12/04/1946 65 201-36-4009 Director 1 **X**M 2 □ F Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location must be notified at Director Md. 1X Yes 2 ☐ No P.G. District Heights 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? 6 23a Funeral 7104 Chapparal Drive 20747 U.S.A. items death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

YXX Yes 2 No Examiner Black, White, etc. ģ 1 Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours after C Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or may injury or other traumatic event, the Medical Examinane. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 M No Specify: Black If Yes, Give 65-67 Year or Dates. 3 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Pentagon Elementary/Secondary (0-12) College (1-4 or 5+) U.S. Government years Office Manager Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) George Gullatt မ Thelma Williams 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7104 Chapparal Dr., District Heights, Md. Mary A. Gullatt/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2 🙀 Cremation 3 ☐ Removal from State Chesapeake Crematory, Inc. 01/28/12 Beltsville, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility
Henry S. Washington & Sons Co., Inc.
4925 Burroughs Ave., N.E., Washington, D.C. Signature of Funeral Service Licenses an Approximate Interval Between Onset and Death Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ -ATAL disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Ver Sequentially list conditions. Examine in any, leading to immediate cause. Enter Underlying Cause (Disease or injury Dus to for as a consequence of and that initiated events Due to (or as a consequence of): resulting in death) Last as the burialattending physician Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: nse (23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy for L in the past 12 months? Month Day Year Pregnant at time of death signed by the at 9 Unknown 1 ☐ Yes 2 L 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by pe 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has I autopsy performed?

1 Yes 2 No 1 ☐ Yes 2 📈 No 25. Was case referred to medical 26. Place of Death (Check only one) 2 1 ☐ Yes 2 🗙 No 1 ☐ Inpatient 2 📈 ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at work? 1 Yes 2 No iniury 1 Natural 5 Pending ours after death.

neral Director: A
filled in by the fu Accident Investigation Suicide 6 🗌 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a

To the Funeral D Medical 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) title of certifie 29d. Date signed (Month, Day, Year) 29b. Signature a npleted cause of death (Item 23a) (Type, Print) 30. Name and address of persor

State

Registrar

31. Date filed (Month, Day, Year

JAN 3 0 2012

Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar #1 WCHD ead 2/3 Centificate of Death 2. Date of Death 3. Time of Death Month Year 20/2 Physician/ 0559 AM Gunby Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HICOMICO RAGIONAL MEDICAL SAL136414 If Unde If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) curity Number **Funeral** Days Hours (Month. Day, Year) Director 1 🗆 M 2 😿 F 85 Usual Resider 28a-f show 10d. Inside City Limits 10a. State County 10c. City, Town or Location notified at Director 1 Yes 2 □ No 10e Street and Number 10f. Zip Code 5 10g. Citizen of What Country? must be Funeral 23a 9 06 items Was Deceue... Armed Forces? Vas 2 X No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11 Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian the Medical Examiner Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2 Married ö Completed by Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2X No Specify "natural", 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NQT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last 18. Mother's Name (First, Middle, Maiden Sumame) မ traumatic Lewi 19a. Informant's me/Relationship (Type, Print) Department of Health ar Important: If item 27 is any injury or other trau Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory 4 Donation 5 ☐ Other (Specify) Signature of Fureral Service Licensee Harris 100 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. A roximate Interval Between Onset and Death Immediate Cause (Final Physician/ Myocarlie disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate causa Enter Underlying Examine Due to (or as a consequence of): attending physician and for use as the burial-transi Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: s, outcome of pregnancy Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav 5 Other (specify) Pregnant at time of death signed by the at Id be detached for Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown Records. Completed peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy has page 2 death?
1 Yes 2 No After this certificate Yes 2 X No To the Hospital or Attending Physician: Within 24 hours after death.

To the Funeral Director: After this certifies Division of Vital filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? မ 1 🗌 Yes 2 X No Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 5 Pending iniury 1 💢 Natural Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 20053394 1/23/12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ANTHONY FILM, M.D. 100 E. PAYIALL St.

DHMH 17 Rev 06-2011

State Registrar Registrar's Signature

2

			Please	Type or Pring AMEND ITE State of Ma	nt in B	lack Ir	idelible In	k. Ensure	All Copie WS Mental Hy	s Are	Legible.	
		-	For State RegistrarAmend#23aPrt.						wieritai i iy	Reg. No.	2017	03843
			Decedent's Name (First, Middle, La.						2. Date of De	ath		3. Time of Death
	Physicia Medio		Wesley Gree Glo	ver					Januar	y 11,	2012°	1:30 A. M
	Examin		4a. Facility Name (if not institution, give	e street and number)				or Location of Death	1		County of Deat	_
	F		308 69th Place 5. Social Security Number 6. S	Sex 7 Age	e (In yrs. las	t hirthday)	Seat If Under 1 Year	Pleasant I If Under 24 Hrs.	8. Date of Bir		nce Geo	Drge's hplace (State or Foreign
	Funeral Director		247-58-0494 1 Usual Residence of Decedent	F 7. Age		Yrs.	Months Days	Hours Min.	(Month, Da 09/20/	ay, Year)	936 Cou	eorge, S.C.
	and show	힏	10a. State 10b. County		10c. City,	Town or Loc	cation					10d. Inside City Limits
	Mary 28a-f otifie	Director	Md. E	P.G.	S	Seat F	leasant					1x☐ Yes 2 ☐ No
	th the 3a or t be n	a D	10e. Street and Number 308 69th Place				10f. Zip Code 20743	1			en of What Co •S•A•	untry?
	ath wi	Funeral	11. Marital Status	12. Was Decedent B	ver in U.S.	13. V	Vas Decedent of I	Hispanic Origin? (Sp	pecify Yes or No-		4. Race - Ame	rican Indian,
36	72 hours after death with the Maryland n"natural", or items 23a or 28a-f show Aedical Examiner must be notified at	Completed by F	1 Never Married 2 Married 3 XWidowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates.		1:	Yes, specify Cub	an, Mexican, Puert	o Rićan, etc.)		Black, White Specify: Bl	e, etc.
21215-0036	hours natura lical E	lete	15. Decedent's B	ducation		16a. Deced	lent's Usual Occu	pation	dian	16b. Kir	nd of Business	Industry
218	t in 72 re, than "	티	(Specify only highest gr Elementary/Seconday (0-12)	College (1-4 or 5	+)	life. D	O NOT use retired	•	KING		artment	
121	er er	اما	7th			<u>Ani</u>	mal Ca:	retaker 18. Mother's Nar	no (First Middle		icultur	e
ou o		일	17. Father's Name (First, Middle, Last) Willis Glover						Williar		итате)	
Maryland	1 and 2 should le file if Health and Mental B item 27 is marked o other traumati eve		19a. Informant's Name/Relationship (19b. Mailir	g Address (Street	and Number or Ru			Town, State, Zip	Code)
	nd 2 sl salth a n 27 i		Avon G. King/Sist	ter		309	69th Pla	ace, Seat	Pleasar	nt,Ma	ryland	20743
Baltimore,	e 1 and of Heal If item 2		20a. Method of Disposition 1X Burial 2 Cremation 3	Removal from State	20b. Pla	ace of Dispo metery, cren	sition (Name of natory or other pla	ace)	Date	20c. Lo	cation - City or	Town, State
ţi	t. Pag rtment rtant; njury o		4 ☐ Donation 5 ☐ Other (Special	ify)	Shac		ve Cem.		23/12		George	
Bal	permit. Page 1 a Department of h Important: If ite any injury or of		21. Signature of Funeral Service Licen	M. Or	all	- 22	Henry S	ess of Facility Washing	ton & S	ons (o. Inc	5.C. 20019
		-	23a. Part 1. Enter the disease, or com	plications that caused	the death.						IIGLOHA	Approximate
	hysician/	0 0	shock, or heart failure. List only of Immediate Cause (Final	one cause on each line	hror	ic (PART F	ailure				Interval Between Onset and Death
	Medical		disease or condition resulting in death)	a. Due to (or as			Cristi II	A1107 C				0.101071
	Examiner	7	Securatially list nunditions	U.			ney Dise	ase				
	ed Isit	Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury	Due to (or as	a conseque	ence of):						
	executed an and rial-transit		that initiated events resulting in death) Last	C. Due to (or as	a conseque	ence of):				_		
90		dical		d								
Box 68760	hat the death certificate be ed by the attending physici detached for use as the bu	Physician/Medica	IF FEMALE:	23c. If yes, outcome	of pregnan	CV						
ox (ath ce attend for us	cian	23b. Was decedent pregnant in the past 12 months?	1 Live Birth 4 Pregnant a	2 Fetal	death 3	Ectopic pregnar Other (specify)	псу		2	3d. Date of del Month	livery Day Year
W	he de y the iched	hysi	1 Yes 2 No 9 Unknown	9 🗌 Unknown								
P.O.	Physician: The law requires that the death certificate be this certificate has been signed by the attending physici ral director, page 2 should be detached for use as the bu		Part II. Other significant conditions	contributing to death b	ut not resu	lting in the u	nderlying cause g	jiven in Part I.				the cause of death?
ds,	v requires that s been signed is should be det	ted							1 🗆	Yes 2 L		robably 4 Unknown
of Vital Records,	law re nas be e 2 sh	Completed by							24a. Was	an opsy ormed?		topsy findings available completion of cause of
Re	sician: The law I certificate has k lirector, page 2 s		OF MI	Y					1 Tes	2 No		2 🗆 No
/ital	sician: certific irector,	Be c	25. Was case referred to medical examiner? 1 Yes 2x No	Hospital:			_ Ot	Place of Death (Che	lome 5 🔀 Res	idana C	Other (Case	36.0
of V	g Physer this eral di	e: To	27. Manner of Death	28a. Date of inju	ry 2	28b. Time of	nt 3 DOA 28c. Inju	iry at	28d. Describe			ny)
on	anding sath. or; Afte	ficat	1 Natural 5 Pending 2 Accident Investigation		, year)	injury	M 1 [Yes 2 No				
Division	for Atterdaterde Directo	Certificate:	3 Suicide 6 Could not l 4 Homicide determined		ry - At hor c. (Specify)	ne, farm, str	eet, factory, office			(Street and wn, State)	Number or Ru	ral Route Number,
	To the Hospital or Attending Physwithin 24 hours after death. To the Funeral Director: After this completed filled in by the funeral di	Medical	(Check 2 Medical Exam	ysician: To the best of niner: On the basis of e	xamination	and/or inves	tigation, in my opir	nion, death occurred	at the time, date	and place,	and due to the	cause(s) and manner stated.
	o the	Ĭ	only one) 3 Certifying Nur 29b. Signature and title of certifier	rse Practioner: To the	best of my	knowledge,	29c. Licen	se number		29d. Date	e signed (Montl	h, Day, Year)
	- s - ō) all	KURRIMAN	MO			039262			-18-201	
0	つ		30. Name and address of person who	1 1			Print)					
1			JAY LIMMAN (Manth Day Year)	#50] 32. Registra	F St.	N.W.	# 3300	Washin	gton,D.	C	20001	
	Sta Registr		31. Date filed (Month, Day, Year) JAN 3 0 2012	News 32. Herestra	far	Carl .						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 22 Day Physician/ 201^{Yes} 6:45 AM Timothy O. Humerick January Medical 4a. Facility Name (if not institution, give street and number) 4h City Town or Location of Death 4c. County of Death Examiner Frederick Thurmont 14733 Sabillasville Road 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Oct 3, 1950 Months Days Hours Min 216-54-8430 1 **X** M 2 □ F Director 61 Maryland Yrs 28a-f shov 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County notified at Director Maryland Maryland Frederick Thurmont 1 Yes 2X No 20 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a or ner must be n 21788 USA Funeral 14733 Sabillasville Road death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian Examiner Armed Forces? 1968 Black White etc 5 Š 1 Never Married 2 Married Baltimore, Maryland 21215-0036 within 72 hours after $\frac{\text{USA}}{\text{White}}$ nan "natural", Medical Exan If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify 1972 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working other than " life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) filed within al Hygiene. Cement Company Purchasing Agent traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) age 1 and 2 should be file int of Health and Mental Ft. If item 27 is marked of 2 Emma Kuhn Earl William Humerick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14733 Sabillasbille Road, Thurmont, Maryland 21788 Belinda Humerick - wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition Date 20c. Location - City or Town, State 1 🔀 Burial 2 🗌 Cremation 3 🗌 Removal from State Ъ Department of Important: If any injury or once, Resthaven Memorial 1-27-2012 Frederick, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Home 21702 1621 Opossumtown Pike, Frederick, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Metastatic Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions rany, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of that initiated events resulting in death) Last Due to (or as a consequence of) physician a the burial-Physician/Medical P.O. Box 68760 as the attending IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Month Year Pregnant at time of death 1 ☐ Yes 2 ☐ Unknown Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 2 No 3 Probably 4 Unknown page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate has 1 Yes 2 No Yes 2 Physician: the funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) Be 2 XNo examiner? Hospital Other: 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA မ 4 ☐ Nursing Home 5 🙇 Residence 6 ☐ Other (Specify) Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Hospital or Attending 24 hours after death.

Funeral Director: After (Month, Day, Year) injury work? 1 ☐ Yes 2 ☐ No Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completely filled in by determined City or Town, State) Medical Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🗆 within 2 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of co 29c. License number 29d. Date signed (Month, Day, Year) 25

DHMH 17 Rev 06-2011

102

Registrar

State

Elhamy

31. Date filed (Month,

MD

1-rederick

30. Name, and address of person who completed cause of death (Item 23a) (Type, Print)

21

32. Registrar's Signature

RALLA

5 Kand

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Physician Harkins Tanuary Virginia Elizabeth 2012 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Anne Arundel Arnold 352 Alameda Parkway Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 □ M 2 💢 F 91 234-36-9961 July 12,1920 West Virginia Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f shot other traumatic event, the Madical Exertance until by notified at Arnold 1 ☐ Yes 2 X No MD Anne Arundel Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21012 USA 352 Alameda Parkway Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 72 hours after 1 ☐Yes 2 XNo If Yes, Give 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 🗓 No Specify. þ 3 X Widowed 4 ☐ Divorced Year or Dates: Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Bookbinder Publishing 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) es 1 and 2 should be fill of Health and Mental H item 27 is marked ott Etta McDonald John William Hilling 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 35373 Sussex Lane Millsboro, DE 19966 Patricia Elliott / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date permit. Pages 1
Department of H
Important: If iter
any Injury or ott January 27 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Metro Crematory, INC. Baltimore, MD 2012 4 Donation 5 Other (Specify) P.A. Pare and Address of Facility Barranco & Sons, P.A. 495 Ritchie Hwy, Signature of Funeral Service Licensee Severna Park Funeral He Severna Park, MD 21146 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or the failure. List only one cause on each line. Immediate Cause (Final **Physician** nyocardia lcule resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine and Due to (or as a consequence of) as the burial-O. Box 68760, physiciar death certificate be Physician/Medical signed by the attending plants as detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 ☐ Ectopic pregnancy Month Day 5 ☐ Other (specify) 9 Unknown 9 Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown cate has been si, page 2 should t Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? certificate 1 Tyes 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 5 Pending investigation 1 Alatural 1 □Yes 2 □ No 2 Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical the 29d. Date signed (Month, Day, Year) 29c. License numbe 29b. Signature and title of certifier 0

8 W State

Registrar

JAN 2 6 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar 03846 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 1145 01 Kathryn Louise Hayward Medical 4c. County of Death Examiner 4a. Facility Name (if not institution, give street and r 4b. City, Town, or Location of Death REGIONAL MIDICAL 300136411 HICAMICS If Under 24 Hrs. Birthplace (State or Foreign Country) If Under 1 Year 8. Date of Birth **Funeral** (Month, Day, Year) Months Min 1 🗆 M 2 🔀 F Director 220-68-8825 05 | 09 | 1958 MD 53 Usual Residence of Deced or 28a-f show notified at 10a. State 10h County 10c. City, Town or Location 10d Inside City Limits Director Salisbury 1 Xyes 2 No MD Wicomico items 23a or ner must be n ò 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21804 708 Edgewater Dr., Apt. 202 death v 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. o þ 1 Never Married 2X Married 3altimore, Maryland 21215-0036 nan "natural", o Medical Exam 1 Yes 2 No Specify Specify: Completed 3 Widowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry should be filed within rz in h and Mental Hygiene.

if is marked other than "r (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) K ând L Microwave 12 Industrial Technician Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည MaryBelle Phillips William Joseph Townsend, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) tge 1 and 2 sh nt of Health a t: If item 27 is r or other tran 2324 Hudson Dr., Salisbury, MD, 21804 Heather R. Wingate | Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1X Burial 2 Cremation 3 Removal from State Department c Important: If any injury or 01 26 2012 Salisbury, MD Springhill Mem. Gar. ☐ Donation 5 ☐ Other (Specify) Sign ture of Filter LS., lice Licensee 22. Name and Address of Facility Holloway Funeral HomeP.A. 501 Snow Hill Rd. Salisbury, MD, 21804 Champron 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Retween Immediate Cause (Final and Death Physician/ Liver Failure disease or condition 1 Week Medical resulting in death) Examiner yew Sequentially list conditions, if any localing to introduce cause. Enter Underlying Cause (Disease or injury that initiated events death certificate be executed Due to (or as a consequence of) resulting in death) Last burialphysician Physician/Medical Division of Vital Records, P.O. Box 68760 as attending IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 mooths? for Month Day Year Pregnant at time of death ed by the a 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Fallur Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' certificate 1 Yes 2 No 1 Yes 2 7 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 2 No 1 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this n 24 hours after deau... ne Funeral Director: After thi mietely filled in by the funeral 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: the Hospital or Attending 5 Pending injury work? 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the Hosp within 24 hou To the Funer completely fi 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifier Jan. 22, 2012

Registrar

Bennett

31. Date filed (Mont

, 100 E.

Carroll St.

Salisbury, MD 21801

of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Physician/ 3:56 A.M 2012 Ivancik 30, Richard John January Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Examiner St. Mary's Leonardtown St. Mary's Hospital If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Funeral 1 🕱 M 2 🗆 F (Month, Day, Year) 2/28/1923 Illinois 88 Director 347-14-7392 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County within 72 hours after death with the Maryland Director 1 Yes 2 X No St. Mary's Lexington Park Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral U S A 20653 47906 Long Lane Farm Road or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12 Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify. White "natural", Completed 3 Widowed 4 Divorced of Health and Mental Hygiene. item 27 is marked other than "natur other traumatic event, the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) U.S. Postal Service 12 Letter Carrier Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ Szabo Mary John. Ivancik 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh
Department of Health ar
Important: If item 27 is
any injury or other trau 47906 Long Lane Farm Rd., Lexington Park, MD 20653 Janice T. Ivancik/Wife 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place)
Immaculate Heart of 1 X Burial 2 Cremation 3 Removal from State 02/04/2012 Lexington Park, MD 4 ☐ Donation 5 ☐ Other (Specify) Mary Catholic 21: Superture of Funeral Service Acers 22. Name and Address of Facility
Mattingley-Gardiner Funeral Home, P.A.
41590 Fenwick St., Leonardtown, MD 20650 23a. Park 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final 5514E ₽hysician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** in worth Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events use as the burial-transit and Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 5 Other (specify) Pregnant at time of death Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Vital Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ၉ 1 Yes 28a. Date of injury (Month, Day, Year) of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Certificate: Hospital or Attending 1 Natural 5 Pending Division 2 Accident
3 Suicide Investigation
6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined within 24 hours af

To the Funeral Di

completed filled in Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗆 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

(6) RML State Registrar 25500 Point Lookout Rd., Leonardtown, MD 20650

30. Name and address of person ∯ho completed cause of death (Item 23a) (Type, Print)

Date filed (Month, Day, Year)

			For State Registrar	State of Maryla		artment of F		,	20	112	03848
	D		Decedent's Name (First, Middle, Last)			timodio oi b		2. Date of Dea	Reg. No. 🛴 🔱	1 4	3. Time of Death
	Physicia Media		STEPHEN TROY JOHN	ISON				JAN	22 22	2012	11:03 PM
	Examir	er	4a. Facility Name (if not institution, give str	eet and number)		4b. City, Town, or			4c. County		
	Funeral		5. Social Security Number 6. Sex	7. Age (In vrs	s. last birthday)	If Under 1 Year	ETHESDA If Under 24 H			ONTGO	
	Director		101 30 2437	M 2 □ F	49 Yrs.	Months Days	Hours Mi		0 (Year)	Penn:	lace (State or Foreign sylvania
7	on now	١	Usual Residence of Decedent 10a. State 10b. County	100 (City, Town or Lo	action					
-	anylar ka-fsl ified	Director	Maryland Montgomer		ensingt					10	0d. Inside City Limits 1 Yes 2 □ No
1	or 28	ä	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Count	
1	n with	Funeral	3104 Kent Street			20895			United		
-	r item	/ Fui		2. Was Decedent Ever in t Armed Forces?		Was Decedent of His f Yes, specify Cubar	spanic Origin? (n, Mexican, Pue	Specify Yes or No- erto Rican, etc.)		e - America ck, White, e	
980	saltel ral", o Exam	ed by	1 Never Married 2 Married 3 Widowed 4 Divorced	1 X Yes 2 □ No If Yes, Give Year or Dates, Irac	- 1	I ☐ Yes 2 No			Specify		ack
2-0	'natul dical	Completed	15. Decedent's Educ (Specify only highest grade	ation	16a. Deced	dent's Usual Occupa			16b. Kind of B		
121	than than be Me	lmo	Elementary/Seconday (0-12)	College (1-4 or 5+)	life. D	kind of work done do O NOT use retired)		orking	Govern	ment (Consulting
Q 3	Hygie other sint, the	Be C	17. Father's Name (First, Middle, Last)	5+	Busin	ess Devel			Compa		
ylan	Mental arked a	으	Reginald Johnson					ame (First, Middle, i Le Elizab		-/	
Baltimore, Maryland 21215-0036	performer rage I and 2 should be fined within 12 hours after dearn with the Maryland performer of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationship (Type Joseph Michael John	Print) ason (Son)		ng Address (Street a					
e,	other other		20a. Method of Disposition	20b.	. Place of Dispo	Kent Stre	1	Date	20c. Location -		
imo	ment cant		1 ☐ Burial 2 H Cremation 3 K Re 4 ☐ Donation 5 ☐ Other (Specify)	moval from State	Metropo Crema	natory or other place olitan cory	Jan 2	uary 28, 012		•	Virginia
3alt	Peparti nport ny inj nce.		21. Signature of Funeral Service Licens e	H		. Name and Address					,1181
	70 = 60			M00689		East Dee				ourg,	MD 20877
-			23a. Part 1. Enter the disease, or complic shock, or heart failure. List only one of Immediate Cause (Final				, such as cardia	ac or respiratory am	est,		Approximate Interval Between
PI	nysician/ Medical		disease or condition resulting in death)	ATHEROSCLE Due to (or as a conse		DISEASE				-1	Onset and Death
E	xaminer	.		Dae to (of as a conse	quence on.						
7	A	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a conse	quence of):						
) be executed	and -tra	Examine	Cause (Disease or lingury that initiated events c. resulting in death) Last	Due to (or as a conse	guenne eft					_	
De ex	g physician and as the burial-transfer	dical E	rooding in death) East	Due 10 (0) 23 a conse	quence on.						
3760 ficate b	g phy: as the	Nedi	d.								
x 687	attending p	an/N	Lob. Has account program	. If yes, outcome of pregr		Ectonic pregnancy			23d. Dat	te of deliver	у
P.O. Box 6876(that the death certificate	the at hed fo	Physician/Me	in the past 12 months? 1 Yes 2 No 9 Unknown	4 ☐ Pregnant at time of 9 ☐ Unknown		Other (specify)			Mo	nth [Day Year
Frat th	ed by detac	Ph	Part II. Other significant conditions contr	ibuting to death but not re	esulting in the u	nderlying cause give	en in Part I.	23e. Did to	bacco use contr	ibute to the	cause of death?
	000	ed by									ably 4 🗆 Unknown
Hecords , The law requires	as bee 2 sho	Completed						24a. Was a			sy findings available
Pe ∏	cate has	Som						autop: perfor 1 X Yes	med?	death?	pletion of cause of
Physician: The	is certificate director, pag	m	25. Was case referred to medical examiner?	pital:			ce of Death (Ch				
Phys	r this rall dir	으	1 ☐ Yes 2 X No 27. Manner of Death	1 v Inpatient 2 2 28a. Date of injury	ER/Outpatien	t 3 DOA Other	4 ☐ Nursing	Home 5 Reside			
on C	ath.	icate	1X Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	injury	work?		28d. Describe ho	w injury occurre	ed	
DIVISION Of VITAL tal or Attending Physician:	recto	Certificate:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h		et, factory, office		28f. Location (St	reet and Numbe	er or Rural F	Route Number,
Jalo Sitalo	urs af							City or Town	,		
Hosp	within 24 hours after death. To the Funeral Director. After this concluded filled in by the funeral dire	Medical	(Check 2 in Medical Examiner	an: To the best of my know	on and/or invest	cation in my onlinion	death occurred	t at the time date or	d place and due	to the cours	le state ve a acces le ac (e/e)
To the	within To the comp	— r	only one) 3 Certifying Nurse P 29b. Signature and title of certifier	ractioner; to the best of h	ny knowledge, d	eath occurred at the 29c. License	time, date and p	lace, and due to the	cause(s) and ma	nner as stat	ed.
	2041		· ano	2 11		DE	C1 000	7581	Janua		5 2012
			30. Name and address of person who com		m 23a) (Type, P					,	/
			ANDREW G. LETIZIA		ature - 2		C, BETH	ESDA, MD	20889	5600	
	Stat Registra	e ir	31. Date filed (Month, Day, Year) JAN 26 2012	32. Registrar's Sign	1. pa	Kad.					
				1							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible State of Maryland / Department of Health and Mental Hygiene State
Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 12:25 P M Lynne E. Kirchner January Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Anne Arundel 107 Stone Point Drive, #160 Annapolis Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) . Social Security Number **Funeral** (Month, Day, Year) Min Director 1 🗆 M 2 🗶 F 51 098-40-1184 2/22/1960 New York Usual Residence of Decede 10d. Inside City Limits 28a-f show 10a. State 10b. County 10c. City, Town or Location must be notified at Director 1 🗌 Yes 2 😾 No Maryland Annapolis Anne Arundel 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe 'n 23a USA 21401 107 Stone Point Drive, #160 items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XNo If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Examiner Black, White, etc. . or i 1 Never Married 2 Married Completed by within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: nan "natural", o Medical Exam White 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) than ' Elementary/Secondary (0-12) College (1-4 or 5+) traumatic event, the Retail 5+ years Store Manager other Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) th and Mental F ပ Patricia Miles Dominic Grenci l and 2 should b f Health and Mei tem 27 is mark 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 17 Compton Court, Basking Ridge, NJ 07920 Philip Grenci/ Brother 20c. Location - City or Town, State 20a, Method of Disposition 20b. Place of Disposition (Name of Date Page 1 cemetery, crematory or other place, Important: If it any injury or o ☐ Burial 2 X Cremation 3 ☐ Removal from State Kalas Crematory 1/25/12 Edgewater, MD 4 Donation 5 Other (Specify) of Fineral Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final .Phy.ician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to him reduce cause. Enter Underlying Cause (Disease or injury Examine burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last the attending physician hed for use as the buria Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death. Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b Was decedent pregnant 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No signed by the atter d be detached for Month Dav Pregnant at time of death Unknown 1 Yes 2 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II. Completed by 1 Yes 2 No 3 Probably 4 Unknown cate has been signated by page 2 should b 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy 2 No 1 Yes Yes 2completely filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 \(\text{Nursing Home} \) 5 \(\frac{1}{2} \) Residence \(6 \) Other (Specify) 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 27. Manner of Death 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending s after death. 1 Yes 2 No Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 24 hours a Funeral C Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

State Registrar

within 2 To the I

(Check

urtis

29b. Signature and title of certifier

turber

all 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

003

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

medical Parkway Suite 210 Annapolis mo 2140

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ auton 17 - 2012 45AM Medical 4a. Facility Name (if no institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PRINCE Myronal GEORGES . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 ▼ M 2 □ F 54 Months Hours Min Mary land JU17928, 1957 216-64-4834 Director Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Director must be notified Maryland Laurel 1 🗆 Yes 2 🛚 No Anne Arundel 10e, Street and Number 0 10f. Zip Code 10g. Citizen of What Country? by Funeral 20724 United States 23a 52 South Bruce Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 X Never Married 2 ☐ Married ō Baltimore, Maryland 21215-0036 1 ☐ Yes 2 √2 No Specify: "natural", 3 Widowed 4 Divorced Specify: White Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, the Meonce. Elementary/Seconday (0-12) College (1-4 or 5+) Service Tech Gas Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Jeanette Page Clayton Robert Knapp, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
9202 51st. Avenue College Park, Maryland 20740 19a. Informant's Name/Relationship (Type, Print) Patricia Scully -sister 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place Metropolitan Crematory Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 1/18/2012 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee Donald Voor Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ Respirato disease or condition resulting in death) Medical **Examiner** Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last for use as the burialattending physician Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Pregnant at time of death 5 Other (specify) been signed by the a should be detached it 1 ☐ Yes ∠ ☐ 9 ☐ Unknown 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has l autopsy certificate 2 No 1 Yes 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify ၉ 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA this 28c. Injury at work?
1
Yes 27. Manner of Death 28a. Date of injury 28b. Time of Medical Certificate: 28d. Describe how injury occurred After (Month, Day, Year) 5 Pending injury Natural within 24 hours after death.

To the Funeral Director: Afcompleted filled in by the fu 2 🗀 No 2 Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 🗄 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) D68782 17, G~mm~ MD 7300 Van Dusen Rd.

State Registrar 31. Date filed (Month, Day, Year)

JAN 19 2012

Adedy Men

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Charlotte Koogle Zimmerman Kessinger 30, 2012 8:40 PM M January Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Frederick Tranquillity at Fredericktowne Frederick If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) ocial Security Number 7. Age (In yrs. last birthday) **Funeral** Hours 214-14-6051 Director 1 M 2 F 90 Nov. 19, 1921 Virginia 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director notified Frederick Frederick Maryland 1 □yes 2 □ No 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Numbe or must be r 21703 Funeral 6441 Jefferson Pike items death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race ~ American Indian, Black, White, etc. or, þ 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene.
The 127 is marked other than "natural", or any or other traumatic event, the Medical Examinary or other traumatic event, the Medical Examinary. Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify. White 3 Widowed XX Divorced Specify Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Government Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Hazel Rebecca Koogle Jeptha McCulloh Zimmerman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
7439 Hayward Road, Frederick, MD 21702 19a. Informant's Name/Relationship (Type, Print) Mrs. Candice G. Kelly, daughter 20a. Method of Disposition
1
Burial 2
Cremation 3
Removal from State 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Department Important: If any injury or Smithsburg Crematory Feb. 1, 2012 Smithsburg, MD 4 Donation 5 Other (Specify) Signatore of Funeral Service Ligensee Keeney and Bastord PA Funeral Home M00255 106 East Church St., Frederick, MD 21701 23a. Part 1. Enter the disease, or complicat shock, or heart failure. List only one can ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest use on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ wention disease or condition Medical resulting in death) **Examiner** Sequentially list conditions if any, leading to immediate cause. Enter Underlying Due to for as a consequence on Examir Cause (Disease or injury that initiated events the burial-tra Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death been signed by the a should be detached t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed 24 hours after death. Funeral Director: After this certificate I 2 🗌 No 1 Yes 25. Was case referred to medical the funeral director, 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Certificate: To 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred Natural 5 Pending Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2. only one) 29b. Signature and title of certifier

DHMH 17 Rev 06-2011

State

Registrar

rack

Waseem, 1126 Opal Court, Hagerstown, Maryland 21740

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Si

31. Date filed (Month, Day, Year,

29c. License number

29d. Date signed (Month, Day, Year)

			For State of Maryl 1 - State Registrar		artment of F rtificate of I			iene _{ea. No.} 2 ()12	0385	2
Е	Tor.	e.	Decedent's Name (First, Middle, Last)				2. Date of Deat Month	h	Vaar	3. Time of Death	_
	Physicia /Medic	-	ANNA ROSELIA LITTLE				JANUARY	21,	2012	7:25 P M	
4	Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	r Location of Death		4c. County	of Death		
	404000		St. Catherine's Nursing Cente		Emmitsbu			Frede			
	Funeral		1 M 2 T F 00	yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,			ace (State or Foreign ry)	ſ
b	Director		21.4-28-5882 Superior Security	110.			Jan. 28,	1929	Mary:	Land	_
	land ow			. City, Town or Lo	cation				10	d. Inside City Limits	
	Many I-f sh fied	tor	MD Frederick	Emmits	burg					1 X Yes 2 □ No	
	or 28g	Director	10e. Street and Number		10f. Zip Code		1	0g. Citizen of	What Count	try?	
	th will		331 South Seton Avenue		21727			U.S			
	r dea	Funeral	11. Marital Status 12. Was Decedent Ever Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 ₺ No	in U.S. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Origin? (S an, Mexican, Puert	pecify Yes or No- o Rican, etc.)		ce - America ck, White, e		
20	s afte	by Fi	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		1 □ Yes 2 X No	Specify:		Specif	y: 1.1	hite	
215-0036	hour tural	ed b	15. Decedent's Education	16a. Dece	dent's Usual Occup	pation	T	16b. Kind of B			
Ċ	in 72 n "na Aedic	plet	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give	kind of work done DO NOT use retired	during most of word)	king			,	
717	y with	E	8	Sea	mstress			Clothi	ng Fa	ctory	
פ	be filed within 72 hours after death with the Maryland ital Hygiene. id other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Be Completed	17. Father's Name (First, Middle, Last)				ne (First, Middle, i		ne)		
<u>a</u>	should be filed ind Mental Hygi is marked other umatic event, t	၉	Jacob Topper			Hel					
Maryland	2 short and is maintain.		19a. Informant's Name/Relationship (Type. Print)	ı	ng Address (Street			-			
	and lealth m 27 her ti		Linda Carty / Daughter 20a. Method of Disposition 20	0b. Place of Dispo	North Co	arroll St		20c. Location		21.788	
ĕ	Pages 1 and 2 should buent of Health and Ments int: If item 27 is marked iny or other traumatic en		1 Burial 2 □ Cremation 3 □ Removal from State	cemetery, cre	matory or other plac	i			•		
Baltimore,	it. Partmen	l	4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service (censee		nel Cemet		26/2012 7	hurmon	t, Ma	ryland	
Вa	permit. Pages Department of Important: If it any injury or once.		Robert E XX 1115	Ro	bert E. 5 East M	Dailev &	Son Fune	eral Ho	mes, aryla	P.A. nd 21788	
			23a. Part1. Enter the disease, or comblications that called the shock, or heart failure. List only one cause of each line.							Approximate Interval Between	
	Physician		Immediate Cause (Final disease or condition	vance	Δ	emer	itis.		1	Onset and Death	
	/Medical		resulting in death) Due to (or as a cor	nsequence of):	-		340/11/7/11			1	
Q.	Examiner	ъ.	Sequentially list conditions, bb.								_
	led sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of Marry that initiated events	nsequence oi).							
	xecui al-trar	xar	that initiated events resulting in death) Last C Due to (or as a con	nsequence of):		· · · · · · · · · · · · · · · · · · ·					_
8760,	cate be executed physician and the burial-transit	dical E	d								
9	ifficate g phy as the	edic									_
Box	The law requires that the death certific thas been signed by the attending to agge 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □		⊒Ectopic pregnanc	ev.			ate of delive		
	deat he att	sicia	1 Yes 2 No 4 Pregnant at time		Other (specify)			M	onth	Day Year	
О	at the I by the	hy	9 Li Unknown			- Control	00 - Didde	h a a a a u a a a a a	Authorita da Ab	ne cause of death?	_
	res th iigned be de	by	Part II. Other significant conditions contributing to death but no	t resulting in the u	inderlying cause giv	ven in Part I.	23e. Did to	1/		ably 4 □Unknown	1
000	requi	ted	T y ferrans								_
Vital Records,	B 8 0	Completed	Note in all	_			24a. Was a autop perfor	sy	Were autor prior to cor death?	psy findings available npletion of cause of)
a	r. Th		Divilia Meta	Cis			1□ Yes	2 No	1 ☐ Yes	2□ No	_
	tending Physician: The law eath. tor: After this certificate has the funeral director, page 2 s	Be c	25. Was case referred to medical examiner? 1 Yes 2 No	2 ER/Outpatie	nt 3 DOA Oth		ath <i>Check onl or</i> Home 5 ☐ Resid		has (Casait	u)	
o	y Phy er this	<u>ان</u>	27. Manner of D ath 28a. Date of Injury	28b. Time o			28d. Describe h			<u>//</u>	_
0	ndlng th. r: Affe e fun	tion	1 Natural 5 □ Pending (Month, Day Yea 2 □ Accident investigation	ar) Injury		rk? I]Yes 2 ☐ No					
Division or	Atte er des recto by th	Certification:	3 Suicide 6 Could not be 4 Homicide 6 Could not be determined 28e. Place of injury - building, etc. (S	At home, farm, st	reet, factory, office		28f. Location (S City or Tow	treet and Num	ber or Rura	l Route Number,	
5	urs after or arter or										_
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director;	Medical	29a. Certifier (Check only one) 1 CertifyIng Physician: To the best of my dedical Examiner: On the basis of examiner and manner stated.								
	To th within To th comp	Me	29b. Signature and title of cartifier	11 hr	29c. Licens	se number	_ :	29d. Date sign	ed (Month,	Day, Year)	
) Us truo	M IVI	7 700	1870)	1/2	1-3	2	
×			30. Aame and address of person who completed cause of death	(Item 23a) (Type	Print) A	F.	. 7. 1	-	MA	21727	_
			31. Date filed (Month, Day, Year) 32. Registrar's	S. Seton	Nove.	- mn	rits bu	1.9	MD	21/2/	_
	Sta		31. Date filed (Month, Day, Year)	A. d.	backer			,			

DHMH 17 Rev 1/2001

				partment of Health and	Mental Hygi	ene		
			State Registrar Certificate of Death Reg. No. 2			2 03853		
	1. Decedent's Name (First, Middle, Last) 2. Date of De Physician/ Month					Day Yea 2011		
	Medic	Medical Carol PaoLing Lee January					2 8:50 P ^M	
	Examin	er	11516 Pleasant Meadow Drive	4c. County of De				
200	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda		8. Date of Birth		gomery Birthplace (State or Foreign	
	Director		213-45-0412 1 M 2 M F F7 Yrs	Months Days Hours Min		(ear)	Country)	
	d d	L	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town of	Legation	10/14/19	754 1	aiwan	
	arylan a-f sh fied a	Director	, , , , , , , , , , , , , , , , , , , ,				10d. Inside City Limits 1 ☐ Yes 2 🕱 No	
	or 28;	Ë	Maryland Montgomery N. Poton 10e. Street and Number	10f. Zip Code	10	g. Citizen of What		
	with the 23a east pe	eral	 11516 Pleasant Meadow Drive	20878		Jnited St		
	tems er mu	Funeral	11. Marital Status 12. Was Decedent Ever in U.S.	Was Decedent of Hispanic Origin? (S	pecify Yes or No-		merican Indian,	
တ္ထ	fter d , or i	þ	1 ☐ Never Married 2 🛣 Married ☐ 1 ☐ Yes 2 🛣 No If Yes, 2 If Yes	If Yes, specify Cuban, Mexican, Puer 1 Yes 2 X No Specify:	to Rican, etc.)	Black, W		
ğ	ours a tural' al Ex	Completed	3 Widowed 4 Divorced Year or Dates.			Specify: A	sian	
င်	72 hc n "na Aedic	nple	(Specify only highest grade completed) (G	cedent's Usual Occupation ive kind of work done during most of wo a. DO NOT use retired)	orking	6b. Kind of Busines	ss/Industry	
212	vithin jiene. er tha the 1		Elementary/Secondary (0-12) College (1-4 or 5+)	ak Teller		Banking		
Maryland 21215-0036	be filed within 72 hours after death with the Maryland antal Hygiene. ked other than "natural", or items 23a or 28a-f show c event, the Medical Examiner must be notified at	Be	17. Father's Name (First, Middle, Last)		me (First, Middle, Ma			
<u>Na</u>	e 1 and 2 should be filed with of Health and Mental Hygien If item 27 is marked other th r other traumatic event, the	일	Chi-Ming Huang	Yu-Cl	hen Liu			
lan.	shoul and l is ma auma		19a. Informant's Name/Relationship (Type, Print)	ailing Address (Street and Number or Re	ural Route Number, C	City or Town, State,	Zip Code)	
	ind 2 lealth im 27 her tr			16 Pleasant Meado	w Drive, N	N. Potoma	c, MD 20878	
Baltimore,	ge 1 ant of h			sposition (Name of crematory or other place)	Date 2	0c. Location - City	or Town, State	
	it. Page intment o intant: If njury or			litan Crematory 1	/25/2012 A	lexandri	a, Virginia	
Ra	permit. Page 1 Department of Important: If i any injury or o		21. Signature of Funeral Service Lings	22. Name and Address of Facility Down 10 East Deer Park Gaithersburg, MD	evoj rune: Drive 20878	cal Home	,	
			23a. Part 1. Enter the disease, or complications that caused the death. Do not				Approximate	
~~	Physician/		shock of heart failure. List only one cause oh each line. Immediate Cause (Final				Interval Between Onset and Death	
	Medical	0.7	disease or condition resulting in death) Breast Cancer a. Due to (or as a consequence of):					
	Examiner	L	Sequentially list conditions, b.					
	p # /	nine	if any, leading to immediate Due to (or as a consequence of):					
	and I-trans	Sequentially list conditions, if any, leading too immediate cause. Enter Underlying Cause (Library that initiated events resulting in death) Last b. Due to (or as a consequence of): C. Due to (or as a consequence of): d.						
	be executed sician and burial-transi	dical	i southing in additing the same specific to the sam					
09/	certificate I inding phys use as the	ledi	d			_		
200	certif anding use a	N/u	IF FEMALE: 23b. Was decedent pregnant in the post 12 months? 23c. If yes, outcome of pregnancy 1 □ Live Birth 2 □ Fetal death	0		23d. Date of	delivery	
gox	requires that the death certifica been signed by the attending p should be detached for use as	Physician/Me	1 Ves 2 No 4 Pregnant at time of death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		Month	Day Year	
- -	t the by the stacked	Phy	9 🗀 Onknown					
Ţ.	es tha igned be de	b	Part II. Other significant conditions contributing to death but not resulting in the	ie underlying cause given in Part I.			to the cause of death?	
202	equire bould	etec					Probably 4 🔀 Unknown	
Vital Records,	has the	Completed			24a. Was an autopsy perform	prior t	autopsy findings available to completion of cause of	
ř	sician: The certificate irector, pag		25. Was case referred to medical		1 ☐ Yes 2			
ıta	ysician: The law is certificate has director, page 2	o Be	examiner?	26. Place of Death (Che		SEC01311 1 2		
10	Attending Physi r death. ector: After this o	e: To	27. Manner of Death 28a. Date of injury 28b. Tim	e of 28c. Injury at	Home 5 X Residen 28d. Describe how		ecify)	
	ath. r: Afte	icat	1 X Natural 5 ☐ Pending (Month, Day, Year) injul 2 ☐ Accident Investigation	y work? M 1 ☐ Yes 2 ☐ No				
DIVISION	I or Atten after deat Director: d in by the	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Stre City or Town,		Rural Route Number,	
5	oital o urs af ral Di							
	To the Hospital or Attending Physician: The law requires that the within L4 hours after death. To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detach	edical	29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or in	vestigation, in my opinion, death occurred	at the time, date and	place, and due to th	ne cause(s) and manner stated.	
	o the	Σ	only one) 3 Certifying Nurse Practitioner: To the best of my knowled 29b. Signature and title of certifier	29c. License number		cause(s) and manne d. Date signed (Mo.		
	7710		1 Clark	D37142		January 2		
			30. Name and address of person who completed cause of death (Item 23a) (Typ			Junuary Z	J, 2012	
			Geoffrey Coleman, M.D., 1355 Piccar	d Drive, Suite 10	O, Rockvi	lle, MD 2	0850	
	Stat	e	31. Date filed (Month, Day Year) JAN 26 2012 34. Registrar's Signature					
	Registra	ir	UNIT TO LUIZ KLADON P. 19					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 03854 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Feb 1, Physician/ 2012 5:50 AMM **Timothy** Llewellyn Ralph Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Allegany Cumberland 11821 Mulberry Avenue 5. Social Security Number 9. Birthplace (State or Foreign Country) MD 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Funeral Sep 10, 1954 1 → M 2 □ F **Director** 219-46-2375 Usual Residence of Decedent 28a-f shov 10a. State ortant: If item 27 is mar ed other than "natural", or items 23a or 28a-f sho injury or other traumati event, the Medical Exeminer must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Cumberland MD Allegany 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11821 Mulberry Avenue 21502 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes, 2 No
If Yes, Give
Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: Completed 3 Widowed 4 Divorced white 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) CSX trainman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F ဂ္ဂ Miriam Virginia Livengood Herbert Llewellyn 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11821 Mulberry Avenue Cumberland MD 21502 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh Der artment of Heatth ar Important: If item 27 is any injury or other trau Sandra Llewellyn wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Restlawn Memorial Gardens 2/4/2012 MD LaVale Donation 5 Other (Specify) 21. Signature f Funeral Service 22. Name and Address of Furieral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1. Eller the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final COLORSCTAL Onset and Death Physician/ METASTATIC disease or condition Medical resulting in death) Due to (or as a consequence of) JULY 2011 Examiner Sequentially list conditions any, leading to immediate cause. Enter Underlying Due to for as a consequence on Examir -transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 1 Yes 2 L 9 Unknown ed by t detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Tes 2 No 3, Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 Z 1 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 Ø No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 5 Pending 1 Natural 1 Yes 2 No Accident Investigation within 24 hours after death To the Funeral Director: , completed filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the wat of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check To the within 2 only one 3 29b. Signature and title of cer 29c. License number 29d. Date signed (Month, Day, Year) Fel 1,2012 D0023371 erson who completed cause of death (Item 23a) (Type, Print) Name and address M.D. 12502 Willowbrook Rd . Ste. 440 Cumberland, M.D. 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Box 68760

P.O.

Division of Vital

DHMH 17 Rev 1/2001

Registrar

oy Bennett M	oore		epartment of Certificate of			Reg. No. 201	2 0385
Physici edical Exam		Decedent's Name (First, Middle,Last)	14		2. Date of De		3. Time of Death 1232 hrs
eulcai Exam	11161	Troy Bennett 4a. Facility Name (if not institution, give street and number)	Moore 4	b. City, Town, or Location		4c. County of Deatl	
		23660 Myrtle Point Road		California		St. Mary's	
Funeral Director		215 - 37 - 7079 1 M 2 F	yrs. last birthday) L 9 Yrs.	If Under 1 Year If Under Months Days Hour	n Adin	Birth (MM/DD/YYYY) 9. Bir B 0 / 1992 Co	
any		Usuar Residence of Decedent 10a. State 10b. County 10c.	City, Town or Location	on			10d. Inside City Limits
Maryland 28a-f show d at once.	ō	Maryland St. Mary's	Califor	nia			1 Yes 2 X No
ith the Maryland 23a or 28a-f sho notified at once,	Director	10e. Street and Number		10f. Zip Code		10g. Citizen of What Cou	ntry?
with the ns 23a c	E	23660 Myrtle Point Road 11. Marital Status 12. Was Decedent Ever	in U.S. 13. Was	20619 Decedent of Hispanic Ori	gin? (Specify Yes or N	U S A	ican Indian, Black,
p, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland (eath and hould bygiene.) teanth and house them "natural", or items 23a or 28a-f she tranmatic event, the Medical Examiner must be notified at once	Funeral	1 X Never Married 2 Married Armed Forces? 1 Yes 2 X	No	s, specify Cuban, Mexican	,	White, etc.	
ırs afte tural", ıminer	É	Widowed 4 Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade complete		Yes 2 X No specify s Usual Occupation (Give		Specify: W	nite Industry
6 72 hor nn "na cal Exp	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)		st of working life. DO NOT	use retired)		-
OO3 within giene. her the	шо	9 17. Father's Name (First, Middle, Last)	<u> </u>	employed	r's Name (First, Middle,	Maiden Surname)	
215 be filed riked of	BeC	Timothy Bennett Moore			stal Lee		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hou Department of Health 2nd Mental Hygene. Important: If item 27 is marked other than "nationary or other transmatic event, the Medical Examinjury or other transmatic event, the Medical Examinjury or other transmatic event, the Medical Examinjury or other transmatic event, the Medical Examinjury or other transmatic event, the Medical Examinjury or other transmatic event, the Medical Examinjury or other transmatic event, the Medical Examinjury or other transmatic event, the Medical Examinjury or other transmatic event, the Medical Examinium of the Medical Examinium o	မှ	19a. Informant's Name/Relationship (Type, Print)				ımber, City or Town, State	
e, M l and 2 Health item 2:			20b. Place of Disposit	ion (Name of cemetery,	Date	ifornia, MD 20c. Location - City or	
MOF Pages ent of nat: If		1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify:	crematory or othe Charles_Me	morial Grd.	1/31/2012	Leonardt	own, MD
Baltimore, permit. Pages 1 an Department of Hea Important: If ites		21. Signature of Funeral Service Licensee	22. Na Ma	me and Address of Facilit	diner Fune	ral Home. P	. A .
Physician	_	23a. Part I. Enter the disease, or complications that caused the d		ttingley-Gai 590 Fenwick mode of dying, such as d			Approximate Interval
Vedical Examiner		failure. List only one cause on each line. Immediate Cause (Final disease a. Hanging					Between Onset and Death
- Adminio		or condition resulting in death) Due to (or as a consequer	nce of):				
	ner	Sequentially list conditions, if any, leading to immediate Due to (or as a consequer cause. Enter Underlying Cause	nce of):				
- ·=	Examiner	(Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequent of the consequent o	nce of):				
68760, certificate be executed nding physician and se as the burial - transit	cal E	d. UNPENDED X AMENDED.					
	Medi	# 5perFI IF FEMALE: 23c. If yes, outcome of	1,G938,4/9 pregnancy	/2013,WS		23d. Date of deliver	,
Box 687 c death certifice the attending pi d for use as th	cian/	23b. Was decedent pregnant in the past 12 months? 1 Live birth 4 Pregnant at time	of do oth	al death 3 Ectopi er (Specify)	c pregnancy	Month [Day Year
Boy te death the att	Physician/N	1 Yes 2 No 9 Unknown 9 Unknown	0111		[00 01		
P.O.	þ	Part II. Other significant conditions contributing to death but	not resulting in the un	derlying cause given in Pa		tobacco use contribute to es 2 ✔ No 3 ☐ Prot	
rds, requir	letec				24a. Was		topsy findings available completion of cause of
performed? death						ormed? death?	'
ital ician: s certifi rector,	Be	25. Was case referred to medical examiner? 1 Voc. 2 No.	2 ER/Outpatient	26 Place of Death 3 DOA Other		Residence 6 🗸 Other	r Sana
of V ling Phys After thi funeral di	1: To	1 ✓ Yes 2 No 1 Impatient 2 27. Manner of Death 28a. Date of Injury 1 Natural 5 Pending FOUND: Day, Year)	28b. Time of Inj		c? 28d. Describe	how injury occurred	. Scelle
sion Attendia death. ctor:	atio	2 Accident Investigation Jan 25, 2012	FOUND: 1232 hrs	1 Yes 2 ✓			
25. Was case referred to medical examiner? 1							
e Hospi 24 hou e Fune: etely fi							
To the vithir To the complex	Medical	one) 2 Medical Examiner: On the basis of examinat and manner stated. 29b. Signature and title of certifier	ion and/or investigatio	29c. License number	curred at the time, date	and place, and due to the	
	1	Carae Haronan		O.C.M.E.		January 26, 2012	
- 40.		30. Name and address of person who completed cause of death			MD 04000		
) ene	ate	Carol Allan, MD Assistant Medical Examine 31. Date filed (Month, Day, Year) 32. Registrar's Signary		nore Street, Baltim	ore, MD 21223		
	tate	IAN 9 1 2012	A Louis				

DHMH 17 Rev 1/2/001 OCME 2006 OCME

ORIGINAL

 .,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			p
State of Maryland	Department of He	ealth and Mer	ntal Hygiene

2012	0	3	8	5	
------	---	---	---	---	--

James T McCandle	1- For State	of Maryland / D	epartment of l Certificate of L			201 ag. No.	2 0385
Physician/ Medical Examiner		st) McCandless,]	III		2. Date of Deat Month January 24	th Day Year	3. Time of Death 1755 hrs
	4a. Facility Name (if not institution, gi 142 Gali Sanchez Way	ve street and number)		City, Town, or Locati Villersville	on of Death	4c. County of Death Anne Arundel	
Funeral Director	5. Social Security Number 6. S 445–58–6165		yrs. last birthday) 43		1.0		thplace (State or gn Germany ountry)
ow any	Usual Residence of Decedent 10a. State 10b. County MD Anne An		c. City, Town or Location				10d. Inside City Limits 1 Yes 2 X No
the Maryland a or 28a-f she tiffied at ooce	10e. Street and Number 7915 Delmont Sta			0f. Zip Code 21144	10	0g. Citizen of What Cou	
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show iojury or other traumatic event, the Medical Examiner must be notified at ooce. To Be Completed by Funeral Director	11. Marital Status 1 Never Married 2 Marrie	12. Was Decedent Eve Armed Forces? 1 Yes 2 X	No If Yes		Origin? (Specify Yes or Nocan, Puerto Rican, etc.)	White, etc.	ican Indian, Black, hite
5-0036 ed within 72 hours a tygiene. other than "natura the Medical Exami Completed b	15. Decedent's Education (Specify of Elementary/Secondary (0-12)	conly highest grade complet College (1-4 or 5+)	during most	of working life. DO N Manager		Athletic Associati	
21215-0 could be filed w d Mental Hygis s marked other fic event, the ITO Be Co	17. Father's Name (First, Middle, Las James Thomas Mc(19a. Informant's Name/Relationship (•	19b. Mailing A	Pa	ther's Name (First, Middle, N Aula Ahrens Number or Rural Route Nurr		e, Zip Code)
ore, MD es 1 and 2 sh of Health and If item 27 is her traumat	Meredith McCand 20a. Method of Disposition 1 Burial 2 X Cremation 3	Removal from State	20b. Place of Disposition crematory or other	n (Name of cemetery place)	January 26,	20c. Location - City or	Town, State
Baltimo permit. Pag Department Important: iojury or od	4 Donation 5 Other Specifical Signature of Funeral Service Lice	/.	Metro Crema 22. Nar Barr 495		ns, P.A. Seve	Baltimore erna Park F erna Park,	uneral Home
Physician 23g Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions. Asphyxia							Approximate Interval Between Onset and Death
), be executed sician and urial - transit edical Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as a conseque	ence of):				
). Box 68760, the death certificate be copy the attending physicistic or use as the burning Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknow	23c. If yes, outcome of 1 Live birth 4 Pregnant at time	2 Fetal	death 3 Ect	opic pregnancy	23d. Date of deliver Month	y Day Year
P.C es that igned be deta	Part II. Other significant conditions	contributing to death but	t not resulting in the und	erlying cause given ir		sy prior to or med? death?	pably 4 Unknown utopsy findings available completion of cause of
of Vital Recion Physician: The International director, page on: To Be Com	25. Was case referred to medical	Hospital: 1 Inpatient	2 ER/Outpatient 3	DOA Other	ath (Check only one) Nursing Home 5	Residence 6 Other	
Division of Vital Records, To the Hospital or Atteodiog Physician: The law requin Within 24 hours after death. To the Funeral Director: After this certificate has been a completely filled in by the funeral director, page 2 should bedical Certification: To Be Completec	1 Natural 5 Pending 2 Accident Investiga 3 Suicide 6 Could no	(Month, Day Year) Jan 24, 2012 tion 28e. Place of Injury	0000 hrs - At home, farm, street,	1 Yes 2	✓ No Subject four g, etc. 28f. Location (S	nd hanging Street and Number or Ru	ural Route Number, City
The state of the s						e(s) and manner as stat	ed.
To the He within 24 To the Fe To the Fe Completely completely	29b. Signature and title of certifier	and manner stated.		29c. License numl O.C.M.E.	ber	29d. Date signed (Mo January 25, 2012	
State Registrar	31. Date filed (Month, Day Year)	ant Medical Examine	er 900 W. Baltim		more, MD 21223		

03858 State of Maryland / Department of Health and Mental Hygiene 2 0 | 2 State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 10:22 P M Virginia F. Magyar January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Hospice Howard Columbia If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In vrs. last birthday) 8 Date of Birth Funeral Days (Month, Day, Year) Director 147-30-4211 1 🗆 M 2 🗶 F Aug. 6, 1938 New Jersey 73 Usual Residence of Decedent show ms 23a or 28a-f shormust be notified at 10b County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Crofton MD Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1447 Jordan Avenue 21114 U.S.A. of Health and Mental Hygiene.
item 27 is marked other than "natural", or items:
other traumatic event, the Medical Examiner mu death v 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 XNo 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Completed by 1 Never Married 2 XMarried 1 Yes If Yes, Give Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2X☐ No Specify Specify: 3 Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Healthcare Registered Nurse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျှ Eugene Fox Muriel Parkes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William M. Magyar/husband 1447 Jordan Avenue, Crofton, MD 21114 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H
Important; If ite
any injury or oth Burial 2 ☐ Cremation 3 ☐ Removal from State Other (Specify) Donation 5 Other (Specify) 1-28-2012 Mitchellville, MD Oak Cemetery 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy, Bowie, Maryland 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition months Medical resulting in death) Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed ed by the attending physician and detached for use as the burial-trar Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Year Pregnant at time of death 1 ☐ Yes ∠ m 9 ☐ Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be lymphoblastic 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Vinknown Were autopsy findings available prior to completion of cause of death? 24a. Was an has autonsy Yes 2 No 1 Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be 2 **N** No Hospital Other: 2 1 🗌 Yes Hospice 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred s after death. (Month, Day, Year) work' 1 Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by determined within 24 hours a To the Funeral I completely filled Medical National Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number D0060634 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 6336 CEDAR JUSEPH BINDU COLUMBIA State 26 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 03859 1 - State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 1752M Oi 3 Orence Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** ANNE ARUNDEL MEDICAL CENTER ANNAPOLIS ANNE ARUNDEL 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs Months Days Hours Min. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months 0772371981 PHILIPPIANS 1 □ M 2 🛣 F 50 **Director** 202-60-0855 Yrs 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c, City, Town or Location Examiner must be notified at Director MARYLAND ANNE ARUNDEL 1 Yes 2 No ANNAPOLIS 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 1199 GREEN HOLLY DRIVE or items 23a Funeral 21409 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify: Specify. "natural", 3 ☐ Widowed 4 ☐ Divorced Completed traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4 or 5+) 12 LAW FIRM PARALEGAL Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, and Mental I PAQUITO ANOTADO LILLIAN GUAZON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh
Department of Health ar
Important: If item 27 is
any injury or other trau JIM MARINO 1199 GREEN HOLLY DRIVE ANNAPOLIS, MD 21409 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State CRÓWNSVILLE VÉTERANS CEMETERY 1 A Burial 2 Cremation 3 Removal from State O2/01/2012 CROWNSVILLE MARYLAND
22. Name and Address of Facility LASTING TRIBUTES BY FELLOWS
HELFENBEIN & NEWNAM CREMATION & FUNERAL CARE P.A.
814 BESTGATE ROAD ANNAPOLIS, MD 21401 4 Donation 5 Other (Specify) 21. Signature Puneral Service Lic 23a, Barti. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final tabolic acidoss Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence oi) Exami Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical requires that the death certificate be Box 68760 IE FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy Year Month Day Pregnant at time of death Unknown g Unknown been signed by to should be detach Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed After this certificate h 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medica 26. Place of Death (Check only one) Be Hospital Other: 1 Yes 24 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) ည 28b. Time of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28d. Describe how injury occurred Certificate: 28c. Injury at 1 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending death. 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State)

Hospital or Attending Physician: Funeral Director: After this etely filled in by the funeral Medical Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 250 ROAD State JAN 26 2012 Registrar DHMH 17 Rev 06-2011 ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month /15/2012 Physician/ 05:25 SHARON YVETTE MOORE Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Montgomery Montgomery General Hospital Olney, MD If Under 1 Year If Under 24 Hrs . Age (In yrs. last birthday 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign NCountry) 1 🗆 M 2 🔀 F Months Days Hours Min. 44 *1*//17/1967 Director <u>577-08-0296</u> Usual Residence of Decedent 23a or 28a-f show 10b. County 10a. State 10c. City, Town or Location traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Directo 1 X Yes 2 No Silver Spring MD Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A 20906 14124 Rippling Brook Drive Hygiene. other than "natural", or items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced Specify: Year or Dates Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Goddard Elementary/Seconday (0-12) College (1-4 or 5+) Executive Assistant-Greenbelt|Administration 1 and 2 should be filed wit f Health and Mental Hygier item 27 is marked other 2+ Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Linda Miller Jackie Rav Moore 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1838 Bryant Street, NE, Washington, DC 20018 Antoinette Moore / daughter permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other th 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Gate Of Heaven Silver Spring, MD 4 Donation 5 Other (Specify) 1/21/2012 22. Name and Address of Facility Snowden Funeral Home, P.A. 21. Signatura of Funeral Septice Licensee MO1576 246 N. Washington Street, Rockville, MD 20850 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or BREAST CANCER Exami that the death certificate be executed and L that initiated events resulting in death) Last Due to (or as a consequence of) burial attending physician Physician/Medical Box 68760 for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy 5 Other (specify) Month Day Year Pregnant at time of death detached 9 Unknown þ s been signed b should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe this certificate 2 🗌 No 1 Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? funeral director, Be Division of Vital 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No ဂ္ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work To the Hospital or Attendil within 24 hours after death. To the Funeral Director: A 1 Yes 2 No Accident Investigation filled in by the Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. peted (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated KARLLOVTOBYMD 29c. License number

State Registrar

31. Date filed (Month, Day, Year, 19

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 03861 State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Henry Morgan Monroe 2012 Medical 14 6:30 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Brighton Gardens North Bethesda Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. Date of Birth (Month, Day, Year) 10-7-1926 7. Age (In yrs. last birthday, **Funeral** 9. Birthplace (State or Foreign 1 X M 2 - F Months Days Min. Hours Country) 85 **Director** Virginia 226-20-8500 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State Page 1 and 2 should be filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD Bethesda Montgomery 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 9409 Seddon Road 20817 United States items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian Black, White, etc. "natural", or ģ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: WHITE Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) the General Contractor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျှ Robert Morgan Monroe Mary Jane Foster 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20852 permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 1356 Hollowstone Dr., North Bethesda, Maryland Peter Monroe - Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Hartwood Church Cem. 1-17-2012 Stafford Co., Virginia 21. Signature of Fune at Service License 22. Name and Address of Facility Danzansky-Goldberg 1170 Rockville Pike, Rockville, Maryland 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ a Congestive Heart Failure Medical resulting in death) Due to (or as a consequence of) **Examiner** Advanced Dementia Sequentially list conditions, if any leading L immediate ie to for as a consequence of cause. Enter Underlying Cause (Disease or iinjury that initiated events Examin Hospital or Attending Physician: The law requires that the death certificate be executed Cerebrovascular Accident Due to (or as a consequence of): resulting in death) Last the buri Physician/Medical Division of Vital Records, P.O. Box 68760 attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Pregnant at time of death Year 1 Yes 2 No the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ sign be Completed 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X No certificate 1 Yes 2 No funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4X Nursing Home 5 Residence 6 Chter (Specify) မ 1 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred injury 1 X Natural 5 Pending Investigation 1 ☐ Yes 2 ☐ No Accident filled in by the 24 hours after deal Funeral Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Consigning Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 **To th**e I only one) 3 🗆 29b. Signature and title of 29c. License numbe 29d. Date signed (Month, Day, Year) D30132 1-15-2012

Registrar
DHMH 17 Rev 7/2009

State

30. Name and

31. Date fil

R**‡**ta

Chosh,

Day, Year)
1 2 6

MD

#161, Rockville, Maryland 20850

s of person who completed cause of death (Item 23a) (Type, Print)

14812 Physicians Ln.

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Jan 24, Physician/ aka Arthur George Mihill Arthur George Mihill, Sr. 2012 8:20 A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Linthicum Tate Hospice House If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) **Funeral** (Month, Day Days XXM2DF Hours Min. Washington, DC 85 T926 Director 579-26-1965 Yrs Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location be filed within 72 hours after death with the Maryland Director 1 Yes 2 X No Martinsburg WV Berkeley 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 25405 43 Crooked Oak Way 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 White Yes 2 No Specify "natural", 3 Widowed 4 Divorced Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Retail Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Marion J. Thew Arthur G. Mihill . Page 1 and 2 should b ment of Health and Mer tant: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6 Deerfield Dr, Pepperell, MA Arthur G. Mihill, Jr. - Son permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Fort Lincoln Cemetery 1/28/2012 Brentwood, Maryland 4 Donation 5 Other (Specify) 4739 Baltimore Ave. Signature of Funeral Service Licensee 22. Name and Address of Facility Gasch's Funeral Home, P.A. Hyattsville, MD 20781 Boythy RAY Royers 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician Bladder Cancer disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to for as a nonsecuence of if any, leading to immedia cause. Enter Underlying Cause (Disease or linjury the Hospital or Attending Physician: The law requires that the death certificate be executed thin 24 hours after death.

The Funeral Director: After this certificate has been signed by the attending physician and use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month Year 5 Other (specify) Pregnant at time of death g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Cardiovascular Disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖾 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 🗌 Yes 2 🗆 No 1 Yes 2 X No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) the funeral director, Be Hospital: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) Hospice 2 XNo ER/Outpatient 3 DOA ဂ္ 1 Tyes 1 Inpatient 2 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of House Certificate: 28c. Injury at 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No 1 X Natural 5 Pending Investigation Accident 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 301 Hospital Dr, Glen Burnie, MD 20161

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Register's Sign

Russell R. DeLuca

31. Date filed (Month, Day, Year, JAN 3 0 2012

0/2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Mensah K. Sarah 23 2012 1940 January Medical 4b. City, Town, or Location of Death Clinton Examiner 4a, Facility Name (if not institution, give street and number) 4c. County of Death Southern MD Hospital Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours 12-22-1925 219-29-3319 Ghana" 1 □ M 2**X** F **Director** 86 Yrs. or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Suitland PG MD 1 X Yes 2 □ No 10g. Citizen of W 10e. Street and Number 9 10f. Zip Code of What Country? ms 23a or must be n Funeral 20746 3022 Irma Ct. items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, er than "natural", or iter the Medical Examiner Armed Force Black, White, etc. þ 1 Never Married 2 Married Yes 2 XNo Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2√☐ No Specify: Black Specify: Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) Give kind of work done during most of working should be filed within 72 h and Mental Hygiene, 7 is marked other than "r life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Ghana Post Office Telecommunications 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)

Mary Coujoe Mensah ൧ Paul Daniel other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is, any injury or other traunonce. Roseline Hammond/Daughter 3022 Irma Ct. Suitland, MD 20746 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State ■ Burial 2 □ Cremation 3 □ Removal from State □ Donation 5 □ Other (Specify) 02-16-2012 Accra, Ghana Ocu Cemetery 22. Name and Address of Facility Ronald Taylor II FH 10583 Middleport In. White Plains, MD 20695 21 Ignature f Funeral Service License Konal 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Ph_sician/ HYPOTENSION disease or condition resulting in death) Medical Examiner PIRATORY Sequentially list conditions, Examine dany, leading to immedicause. Enter Underlying Cause (Disease or injury PERCARBIA Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last physician a s the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death 5 Other (specify) 1 ☐ Yes ∠ № 9 ☐ Unknown g Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 No 3 Probably 4 Unknown page 2 should Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy performe certificate 2 No Yes 1 L Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital Other: 1 Tes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this eral Director: After this filled in by the funeral Manner of Death Date of injury (Month, Day, Year) 28b Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural Accident injury work?
1 Yes 2 No 5 Pending nvestigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) Signa 29d. Date signed (Month, Day, Year)

State Registrar SURRAT

death (Item 23a) (Type, Print)

person who completed car

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 03864 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 26^{Day} 2012 James Francis McTaggart January 9:45 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 6101 42nd Place Prince George's Hyattsville 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Ye 1 🏻 M 2 🗆 F Months Days Hours Director 1937 Johnstone, Scotland 74 Nov. 079-48-0514 Usual Residence of Decedent 23a or 28a-f show 10a. State 10b. County Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD Prince George's Hyattsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funera 6101 42nd Place 20781 items 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No , o Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 X No Specify: "natural", 3 🗌 Widowed 4 🔲 Divorced Specify: Completed White Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) 2 should be filed within 72 hand Mental Hygiene.
7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Community Development Non-profit Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Joseph McTaggart Grace McGhee permit. Page 1 and 2 should Department of Health and M Important: If item 27 is man any injury or other traumat 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy L. McTaggart / Wife 6101 42nd Place, Hyattsville, MD 20781 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) of Heaven Cemetery 1/30/2012 Silver Spring, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 4739 Baltimore Avenue 111 Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ Bod Due to (or as a Sequence of): disease or condition resulting in death) Medical Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. the attending physician and thed for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day 4 Pregnant 9 Unknown Month Year Pregnant at time of death 1 Yes 2 L 9 Unknown been signed by should be detack Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by erebrovascular Discase 1 Tes 2 No 3 Probably 4 Unknown After this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 욘 1 Inpatient 2 I ER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🔂 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier 1 🕰 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Contributing Number Practionar To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Contributing Number Practionar To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check To the within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1/26/2012 MO D37934 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7500 Greenway Center Drive Greenbelt MD 20770 Trifoz Stephanie lia MD

State Registrar 31. Date filed (Month, Day, Year)

JAN 3 0 2012

32. Registrar's Signature

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

•			Plea	ase Type or								_	jible.	
		For State		State of	f Marylaı		artment of		and N	/lental Hy	giene		\ 1 C	00005
		Registrar 1. Decedent's Name	e (First Middle	a Last)		Ce	rtificate o	Death		2. Date of De	Reg. No	. 21		13865
Physicia Medio			oy Nel		is					Januar		ž, 2	0 <u>Ť</u> 2	3. Time of Death 7:30 p M
Examin				, give street and num			4b. City, Town	, or Location	of Death				of Death	h
		Carroll 5. Social Security No		e Dove Ho		la a tha in the classes	West	minste ar Îf Under		Lo Bata (B)		С	arro	
Funeral Director		212-32-3	3011	6. Sex 1 ☑ M 2 ☐ F	7. Age (In yrs. 76	Yrs.	Months Day		Min.	8. Date of Bir July	Year)	935		hplace (State or Foreign untry) MD
nd how at	۱	Usual Residence of 10a. State	Decedent 10b. County		10c. C	ity, Town or Lo	cation							10d. Inside City Limits
faryla 8a-f s tified	Director	MD	Caı	roll		Westm	inster							1 🗌 Yes 2 🔀 No
a or 2 be no		10e. Street and Num	nber				10f. Zip Cod	е			10g. Ci	tizen of	What Co	untry?
th with ms 23 must	Funeral	1050 Bi	rd Hil					1157				USA		
or iter	by Fu	11. Marital Status1 ☐ Never Marri	ied 2 🗍 Mar	12. Was Deced		050	Was Decedent o	ıban, Mexicai	n, Puerto	ecify Yes or No- Rican, etc.)			e - Amer ck, White	rican Indian, e, etc.
ırs afte ıral", I Exar		3 Widowed			`	963	1 ☐ Yes 2【	No Specify.	•			Specify	Wh	ite
72 hou "natu edica	Completed	(Spe	15. Decede cify only highe	nt's Education est grade completed)		(Give	dent's Usual Occ kind of work dor	e during mos	t of work	ing	16b. K	(ind of B	usiness I	Industry
iene. r than	Con	Elementary/Seco	onday (0-12)	College (1-	4 or 5+)	_	O NOT use retire Dreman	ed)				Cons	truc	tion
filed w al Hyg 1 othe vent,	Be	17. Father's Name (F	First, Middle, I	Last)				1		e (First, Middle,		Sumam	e)	
Menta	안		ence Ma					Eli	.zabe	th Dire	cks			
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. In Important: If item 27 is marked other than "natural", or items 23a or 28a-f show may injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Na Scott N.					ng Address (Stre R Bird			al Route Numbe Westmi r				Code)
f Heal item		20a. Method of Disp	osition		20b.	Place of Dispo	osition (Name of	1		Date	_			Town, State
Page nent on ant: If iny or		1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Removal from State 4 Donation 5 Other (Specify) Carroll Cremation Inc 1/30/2012 Hampstead, Maryle												
epartn epartn nporta ny inju		21. Signature of Funeral Service Licensee 22. Name and Address of Facilities Funeral Home & Chapel, I												
₹0 E # 9		00-0-45-4-4	~ V_	7-18)							er,	MD	21157
N		23a. Pad X. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition												Approximate Interval Between Onset and Death
Physician/ Medical		disease or condition resulting in death) a. Due to for as a consequence of):											-	
Examiner	_	Sequentially list cor	nditions	b. ———										
pj.	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Uniform)												
e executed sian and urial-transit	Exar	Cause (Disease or linjuy that initiated events c										-		
cate be e. physiciar s the buris	lical			d										
rtificat ing ph e as th	/Mec	IF FEMALE:												
Physician: The law requires that the death certificate be this certificate has been signed by the attending physici ral director, page 2 should be detached for use as the bu	Physician/Medica	23b. Was decedent in the past 12 n	nonths?		some of pregn Birth 2 - Fel ant at time of	al death 3	3 ☐ Ectopic pregnancy 5 ☐ Other (specify) 23d. Date of delivery Month Day Year						•	
the de by the ached	hysi	1 Yes 2 Unknown	J No	9 🗌 Unkno										
r requires that the des been signed by the s should be detached	by	Part II. Other signifi	icant condition	ons contributing to de	ath but not re	sulting in the u	ınderlying cause	given in Part	ł.					the cause of death?
equire	Completed													obably 4 Unknown
e law e has b ge 2 s	ldmo						-			24a. Was autop perfo			prior to c death?	opsy findings available completion of cause of
an: Th tificate tor, pa	Be Cc	25. Was case referre	ed to medical				26.	Place of Dea	th (Check	1 \(\text{Yes}		0	1 🗌 Yes	2 🗆 No
hysici nis cer I direc	To B	examiner? 1 Yes 2	No	Hospital:	npatient 2	ER/Outpatie		ther:		ome 5 🗆 Resid	dence 6	Oth	er (Speci	My House
fing Parti	ate:	27. Manner of Death	5 Pendir	9	of injury n, Day, Year)	28b. Time of injury	W	ork?	- 1	28d. Describe h	now injur	occurr	ed	Horise
Attenc r death ctor: y y the	Certificate:	2 Naccident 3 Suicide 4 Homicide	6 Could	not be	of Injury - At h	ome, farm, str	M 1 eet, factory, office	Yes 2 C		28f. Location (S	Street an	d Numb	er or Run	al Route Number,
cal or / s after al Dire		4 L Homiciae	determ	buildin	g, etc. (Specif	(y)	,,,			City or Tov			or or 7101	ar riodic realison,
To the hospital or Attending Physician: The law within 24 burus after death. To the Funeral Director. After this certificate has completed filled in by the funeral director, page 2 a	Medical	29a. Certifier 1 (Check 2	Certifying Medical E	Physician: To the be xaminer: On the basi	est of my know s of examination	rledge, death	occured at the tir	ne, date and inion, death or	place, an	d due to the ca	use(s) ar	nd mann	er as state	ted, ause(s) and manner stated.
o the lithin 2 or the lo the lo the lo the lo the lo mple	Μ̈́e	only one) 3 29b. Signature and t	☐ Certifying	Nurse Practioner:	o the best of m	ny knowledge,	death occurred at	the time, date	e and plac	e, and due to th	e cause(s	s) and ma	anner as s	stated. , Day, Year)
		•	D.	Mer	ori		00	071	74	+6	290. Du		26	2 (12
John		30. Name and addre	ess of person	who completed cause	of death (Iter	n 23a) (Type, F	Print)	1 . 1	1		-0	· / ·	1	
		31. Date filed (Month	Day Voorl	nento	SSS		Frint)	IWE	311	ninst	RIC	, wu	20	1157
Stat Registra			0 2012	Museus D	gistrar's Signa	o arked	•							

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			1 - State Registrar			Certific	ate of	Death		Reg. No. 2	012	03866
	Physicia	ın/	1. Decedent's Name (First, Mida	111 1	.,		1		2. Date of De Month		Year	3. Time of Death
إنادانه	Medic Examin	al	Richard 4a. Facility Name (if not institution	William on, give street and number		lein, S		or Location of Deat	Januar		2012 ty of Death	3:25 a ^M
-	LAGIIII	CI	24862 Half Po			45.0		ywood			t. Mar	y " s
	Funeral		5. Social Security Number		Age (In yrs. last birt	hday) If Ur Mont	nder 1 Year hs Days	If Under 24 Hrs Hours Min.			9. Birthp	lace (State or Foreign ry)
	Director		579-40-6449 Usual Residence of Decedent	1 X M 2 □ F	80	Yrs.			11/01/		Wash	ington, DC
	rland f shov d at	tor	10a. State 10b. Count	у	10c. City, Town	n or Location		<u></u>			1	0d. Inside City Limits
	Many 28a-	Director		. Mary's	Ho1	1ywood						1 Yes 2 No
	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral [10e. Street and Number 24862 Half P	one Point Ro	oad	10f.	Zip Code 20	636		10g. Citizen of	What Coun USA	·
	r deatl ir iten		11. Marital Status 1 □ Never Married 2 🕱 Ma	12. Was Deceden Armed Forces	97	13. Was De If Yes, s	cedent of F pecify Cub	lispanic Origin? (S an, Mexican, Puerl	pecify Yes or No- o Rican, etc.)		ce - America	
036	rs after iral", o Exam	ed by	3 Widowed 4 Divorce	If You Give		1 🗆 Ye	s 2 🕱 No	Specify:		Specif		ite
21215-0036	72 hou n "natu ledical	Completed		ent's Education hest grade completed)	16a.		work done	during most of wo	rking	16b. Kind of I	Business/Inc	lustry
212	vithin jiene. er thar the N		Elementary/Secondary (0-12)	College (1-4 o	or 5+)	life. DO NOT	,	Engineer		Civ:	il Ser	vice
nd	filed val Hyg		17. Father's Name (First, Middle,	,					me (First, Middle,	Maiden Surnan		
ylaı	Menta Menta narked	ပ	Frederick	William	Nueslei	n.		Mamie	Virgi	inia	Salte	r
Maryland	shou h and 7 is rr traum		19a. Informant's Name/Relations	_		-		and Number or Ru				
re, I	Healt Hem 2		Henrietta V. 20a. Method of Disposition	Nueslein/Wi	20b. Place of	f Disposition (Name of	one Poir	Date	20c. Location		
Baltimore,	t. Page 1 tment of rtant: If i		1 🛣 Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other	(Specify)	Holly	ry, crematory c wood Cl Nazarei	nurch nurch ne		01/2012	Holly	wood,	MD
Bal	permir Depar Impor any ir		21. That is e of Funeral Service	Vardene	~	22. Name Matt 4159	and Addre	ss of Facility y-Gardin wick St.	er Funer Leonar	al Home	P.A MD 20	650
			23a. Part 1. Enter the disease, of shock, or heart failure. List	only one cause on each l	ine.	not enter the m						Approximate Interval Between
	Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)	a	1+10.		m	ye LOI	nA			Onset and Death
مدروا	Examiner		rooding in dodding	Due to (or a	as a consequence o	of):						
	oit q	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or a	is a consequence o	νij.						
	ficate be executed g physician and as the burial-transit	Exan	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or a	as a consequence o	of):						
0	sician sician buria		, , , , , , , , , , , , , , , , , , ,	d								
8760		Medical	IF FEMALE:	_ u								
9			23b. Was decedent pregnant in the past 12 months?		h 2 🗌 Fetal death			су			ate of delive	•
. Box	e e	Physician/	1 Yes 2 No	4 ☐ Pregnant g ☐ Unknowr	t at time of death n	5 U Other	(specify) _			M	onth	Day Year
P.O.	that the deaned by the a	by Pr	Part II. Other significant conditi	ions contributing to death	but not resulting in	n the underlyir	ng cause gi	ven in Part I.	23e. Did to	bacco use con	tribute to the	e cause of death?
ds,	requires to been signi should be								1 🗆 '	Yes 2 No	3 🗌 Prob	ably 4 Unknown
Records,	law rev	Completed							24a. Was autop	sy	prior to con	sy findings available apletion of cause of
Re	sician: The law i certificate has b lirector, page 2 s								1 Yes	rmed? 2 1 10	death?	2 N o
lital	sician certif irecto	00	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:			Oth	ace of Death (Che er:				
of \	g Phys er this neral di	te: To	27. Mann of Death	28a. Date of in		ime of	28c. Injur	y at	lome 5 Resident Properties 1			
on	endin eath. or: Aft the fur	fical		tigation	Jay, rear)	njury M	work 1 🗆	Yes 2 No				
Division of Vital	pital or Attending Fours after death. eral Director: After filled in by the funer.	Certificate:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	mined 28e. Place of It	njury - At home, far etc. <i>(Specify)</i>	rm, street, fact	tory, office		28f. Location (S City or Tow		per or Rural i	Route Number,
_	To the Hospital or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detach	ledical	(Check 2 Medical	g Physician: To the best of Examiner: On the basis of	f examination and/o	r investigation,	in my opinio	on, death occurred	at the time, date a	nd place, and du	ue to the cau	se(s) and manner stated.
	To the within To the compl.	≥	only one) 3 L Certifyin 29b. Signature and title of certifie	g Nurse Practitioner: To			29c. License	e number		ne cause(s) and 29d. Date sign		
			Dorro	2 m. 7-e	dula.	(N)	2	34198		1/	30/13	_
/	Dane		30. Name and address of person							00000		
15	B) pril		David Feder 31. Date filed (Month, Day, Year)		24035 Thr	ee Not	ch Rd	., Holly	wood, MD	20636		
	Stat Registra	٠ .	FEB 0 1	2012		back						

			1 _ State	-	artment of Healt tificate of Deat			001	2 02067
	V- 24		Registrar 1. Decedent's Name (First, Middle, Last)	Cei	uncate or Deat		Reg. No. 2. Date of Death		3. Time of Death
	Physicia Medic		Stanley	Nowa	k		January	Day 22, 20	
	Examir		4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Locat			4c. County of De	
Branch C	Funeral		Silver Spring Assisted Liver Spring Assisted Liver Spring 6. Sex 7. Age.	(In yrs. last birthday)	Silver S		B. Date of Birth		tgomery irthplace (State or Foreign
	Director		086-18-8352 1 X M 2 □ F		Months Days Hou	urs Min.	(Month, Day, Year,) (Country)
	d t	_	Usual Residence of Decedent	87 Yrs.	agtion		11/24/19:	24	New York
	arylan a-fsh ified a	ecto	Maryland Montgomery	Toc. Oity, Town or Loc		lney			10d. Inside City Limits 1 ☐ Yes 2 🗶 No
	the M or 26	ä	10e. Street and Number		10f. Zip Code	0.109	10g. (Citizen of What C	
	h with ns 23e nust k	Funeral Director	18723 Bloomfield Road		208	832		и	.S.A.
'	or iten	by Fu	11. Marital Status 1 □ Never Married 2 □ Married 12. Was Decedent Event Forces? 1 ▼ Yes 2 □ N	II II	Vas Decedent of Hispanic Yes, specify Cuban, Mex	c Origin? (Specifi xican, Puerto Ric	y Yes or No- can, etc.)	14. Race - Am Black, Wh	
030	rs afte rral", o	ed b	3 X Widowed 4 Divorced If Yes, Give Year or Dates.	WWII 1	☐ Yes 2 🗓 No Spe	ecify:		Specify:	White
2-0	"2 hou "natu edical	plet	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	lent's Usual Occupation and of work done during r	most of working	16b.	Kind of Busines	s/Industry
12	ithin 7 iene.	Completed	Elementary/Secondary (0-12) College (1-4 or 5+	ife. DO	NOT use retired) AID		St	ate Dep	antmont
b	filled wall Hyg	Be	17. Father's Name (First, Middle, Last)			Nother's Name (F	First, Middle, Maide		w vanerve
Maryland 21215-0036	Menta Marked Marice	임	Frank Nowak				Julia	Smith	
Mar	2 shouth and the and the strain t		19a. Informant's Name/Relationship (Type, Print) Tom Chaiyakul - Son		g Address (Street and Nu.				
e,	f Heall item 2		20a. Method of Disposition	20b. Place of Dispos	3 Bloomfield	Date Date		Location - City of	
m	Page nent o ant: If iry or		1 ☐ Burial 2 【 Cremation 3 【 Removal from State 4 ☐ Continuous 5 ☐ Other (Specify)	Everly Cr	natory or other place) Lematory	01/30	ı	•	a, Virginia
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Lice see MDO7	104 15	Name and Address of Fa	acility Ever	ly-Wheat	ley Fune	ral Home
			23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line.				_	screw occu.	Approximate Interval Between
No Vie	Physician/ Medical	ñ	Immediate Cause (Final disease or condition resulting in death)						Onset and Death
	Examiner		Due to (or as a d	consequence of):					
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	consequence of):					
	and transi	Examiner	Cause (Disease or injury that initiated events c.	consequence of):					1
0	ficate be executed g physician and as the burial-transit	edical E	resulting in death) Last	consequence of.					
3760	ificate ig phy as the	Medi	IF FEMALE:						
89 X	th cert ttendin or use	ian/	23b. Was decedent pregnant in the past 12 months?	Fetal death 3	Ectopic pregnancy		,	23d. Date of de	
Bo	re deat	Physician/M	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at t' 9 ☐ Unknown 9 ☐ Unknown	time of death 5 L	Other (specify)			Month	Day Year
<u>О</u> .	that the ned by e detain	by Pr	Part II. Other significant conditions contributing to death but		nderlying cause given in P	Part I.	23e. Did tobacco	use contribute t	to the cause of death?
ds,	quires en sig ould b		History of Prostate Cano	cer			1 🗆 Yes 💈	2 □ No 3 □ f	Probably 4 🗓 Unknown
CO	law re has be e 2 sh	Completed					24a. Was an autopsy	prior to	utopsy findings available completion of cause of
ž	sician: The law scrifficate has b		25. Was case referred to medical				performed?	death?	es 2 🗆 No
Vita	ysicial s certi directo	To Be	examiner?	nt 2 ER/Outpatient	Other:	Death (Check on	5 Residence	6 V Other (See	Assisted
o	ng Phy fter thi Ineral		27. Manner of Death 1 X Natural 5 □ Pending (Month, Day,)	28b. Time of	28c. Injury at work?	1	Describe how inju		cify) Living
ion	ttendideath.	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be		M 1 Tyes 2				
Division of Vital Records, P.O. Box	al or A s after I Direct d in by	2	4 Homicide determined 256. Place of injury building, etc. (/ - At home, farm, stre (Specify)	et, ractory, office	281	Location (Street a City or Town, Stat		ural Route Number,
_	To the Hospital or Attending Physician: The law requires that the death certification 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a	edical	29a. Certifier (Check (mination and/or investi-	gation, in my opinion, deatl	th occurred at the	time, date and plac	e, and due to the	cause(s) and manner stated.
	To the To the complet	Σ	only one) 3 L Certifying Nurse Practitioner: To the b 29b. Signature and title of certifier	Λ	29c. License number		1	ate signed (Mont	
Ō	6+1		► Wilhinson J- Ni	mala	D45	5285	J	anuary :	23, 2012
			30. Name and address of person who completed cause of dear Ninala Wilkinson, M.D., 344	4 Universi	ty Blud., Wes	st, #113	3, Silver	Spring,	, MD 20901
	Stat Registra	c	31. Date filed (Month, Day, Year) JAN 2 6 2012 Lengistrar's	s Signature					
		_							

1/24/2012 00755 Osterman, Joseph

Division of Vital Becords PO Box 68760

		For State	Pleas	e Type or P amend it State of amend	rint in em 10 Marylan #5 Pe	Black II F per Id / Depa r FH G	ndelible In Eh g924 2 artment of I 938 4/09	k. Ensure -16-12 lealth and /2013 JI	All Copic vt Mental H	es Are Le	gible.	00000
		Registrar 1. Decedent's Nam				Cei	rtificate of l	Death	2. Date of D		112	3. Time of Death
Physic Med	cian/ dical	Joseph	Vincent	Osterman,	Sr.					26, 2012	Year	7:55 A M
Exam				e street and numbe			4b. City, Town, o		ath	1	ty of Death	
Funera	al	5. Social Security N		ntist Hos	Age (In yrs. I	ast birthday)	If Under 1 Year			irth		place (State or Foreign
Directo		216-46-7 Usual Residence	993	1 👿 M 2 🗆 F	103	3 Yrs.	Months Days	Hours Mi		1908 19 08	Wash	ington, DC
yland f shov	ţ	10a. State	10b. County		10c. Cit	y, Town or Lo	cation					10d. Inside City Limits
ne Mar nr 28a- notifie	Direc	MD 10e. Street and Nur		George's		Blade	ensburg 10f. Zip Code			10g. Citizen of	18/h at Oass	1 X Yes 2 No
s 23a c	Funeral Director	4004 52n					-	$\frac{20710}{21701}$			SA	nu y !
r death r item		11. Marital Status	ied 2 Married	12. Was Decede Armed Force	s?		Was Decedent of H f Yes, specify Cuba	lispanic Origin? an, Mexican, Pue	(Specify Yes or No erto Rican, etc.)		ce - Americ	
partillior e, Index yiello ZIZ 13-0030 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at	ted by	3 🔀 Widowed		1 Yes 2 If Yes, Give Year or Dates			1 ☐ Yes 2 🗓 No	Specify:		Specif	y: W	hite
13-V	Completed		15. Decedent's cify only highest of			(Give	dent's Usual Occup kind of work done (O NOT use retired)	during most of w	rorking	16b. Kind of I	Business/Ir	ndustry
within giene.		Elementary/Second 12	ondary (0-12)	College (1-4	or 5+)		Police Of			Law En	force	ment
e filed ntal Hy ed oth	To Be	17. Father's Name (,						lame (First, Middle		•	
ould by mark		Vincent 19a. Informant's Na				10b Mailie	ng Address (Street		ie Cathe			Code)
MC Sh d 2 sh salth ar n 27 is er trau				an, Jr	Son	1	ocust Kno					414
ge 1 an t of He or other		20a. Method of Disp 1 X Burial 2		☐ Removal from Sta	ate C	emetery, cren	sition (Name of natory or other place		Date	20c. Location	-	
nit. Pag artmen ortant: injury	il i	4 ☐ Donation 21. Signature of Full	5 Other (Spec		For		oln Ceme		/1/2012	Brentwo	-	
Depire any	olice	3 Signature of Pul	M- E	Car hims			name and Addre Sch's Fu		ome. P.A			more Ave. e, MD 20781
		23a. Part 1. Enter t shock, or hear	he disease, or con rt failure. List only	nplications that cau one cause on each	sed the deatl							Approximate Interval Between
Physician Medica	_	Immediate Cause (disease or condition resulting in death)		a. Er	cep	halo	pathy	y				Onset and Death
Examine	_		ſ	\circ		ience of):						
p iti	Examiner	Sequentially list co if any, leading to im cause. Enter Under	imediate rlying	D.	as a consequ							
executed ian and urial-transit	Exan	Cause (Disease or that initiated events resulting in death) I	3	c. Due to (or	as a consequ	uence of):						
te be e nysiciar he buri	dical		•	d								
ath certifica attending pl	/Me	IF FEMALE:		23c. If yes, outcor	ne of pregna	ncv				· · · · ·		
death c e atten	Physician/Medical	23b. Was decedent in the past 12 r 1 Yes 2	nonths?	1 ☐ Live Birl 4 ☐ Pregnar 9 ☐ Unknow	h 2 🗀 Feta it at time of d	l death 3	Ectopic pregnand Other (specify)	у			ate of deliv onth	Pery Day Year
at the d		9 Unknown Part II. Other signif	icant conditions			ulting in the u	nderlying cause giv	ven in Part I	220 Did	tobaga uso can	tributo to t	he cause of death?
Lires th	ed by						g caace g.					bably 4 Unknown
aw requas bee	Completed		_						24a. Wa:	s an 24b.		psy findings available empletion of cause of
The licate h									per 1 🗌 Yes	formed?	death? 1 Yes	·
s certif	To Be	25. Was case referred examiner?	No Medical	Hospital:	ationt 2	ER/Outpatien	Oth	er:	neck only one) Home 5 🗆 Res	idana C OM		
ng Phy fter this		27. Manner of Death		28a. Date of i		28b. Time of injury		y at		how injury occur		//
Attendi death ctor: A	Certificate:	2 Accident 3 Suicide	Investigation 6 Could not	be 290 Place of	niury - At ho	me farm stre		Yes 2 □ No	29f Location	(Street and Numb	or or Puro	I Pauta Number
tal or A		4 ∐ Homicide	determined	building,	etc. (Specify,)	set, factory, office			wn, State)	er or nura	r rioute ivumber,
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the bu	Medical	29a. Certifier 1 (Check 2	Medical Exar	ysician: To the best	f examination	and/or invest	igation, in my opinio	on, death occurre	d at the time, date	and place, and du	ie to the ca	use(s) and manner stated.
To the within To the compl	Σ	only one) 3 29b. Signature and		rse Practitioner: To	the best of fr	ny knowieage,	29c. License	e number		29d. Date signe	d (Month,	Day, Year)
			esen					00 6R	69	01/26	1201	2
18		30. Name and address	ha Jo	alli mi	5 90	901 r	rint) Nedica	1 Ctr	Dr	Rocki	ille	MD 20850
St Regist	ate trar	31. Date filed (Month	2012 Z	32. Regis	ar's Signat	ure	-					
				7/								

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

			Ple	ase Typ	oe or Pri	int in I	Black	Indelib	le In	k. Ens	ure A	II Copie	s Ar	e Leg	ible.	
		For		S	tate of M	arylan					and N	lental Hy	ygien	е		00000
		State Registrar 1. Decedent's Name	- /Fina Adida	h / 201			С	ertifica	te of L	Death			Reg. N	lo. Z U	12	0380
Physicia		Winifred			ng1 av							2. Date of D Month Januar	D	24 2	Year 2012	3. Time of Death 12:10 PM
Medi Exami		4a. Facility Name (if						4b. City	Town, or	r Location o	of Death	Januar		c. County		12:10 P
, Exami		18431 Ga	rdenia	Way						sburg				Mont		ry
Funeral		5. Social Security N	umber	6. Sex 1 \(\text{M}	2 X F		ast birthda	y) If Unde	r 1 Year			8. Date of B	irth			place (State or Foreign
Director	4	223-14-88 Usual Residence of		<u> </u>		9	0 Yrs.		L			Sept.	1/,1	1921		Virginia
land f shov	ģ	10a. State	10b. County	,		10c. City	y, Town or	Location							1	10d. Inside City Limits
Mary 28a- notifie	Funeral Director	Maryland	Montg	omery			Gaith	ersbui								1 🗌 Yes 2 🛣 No
ith the 23a on at be	la L	10e. Street and Nun						10f. Zi	p Code				10g. C	Citizen of W		ntry?
ath w	nue	18431 Gar	rdenia	_	Vas Decedent	Fver in U.S	S. 1:	3. Was Dece	dent of H	ispanic Orio	gin? (Spe	ecify Yes or No	-		SA Americ	can Indian,
ter de , or it	by	1 Never Marri	ried 2 🗆 Ma	rried 1	rmed Forces?			If Yes, spe	cify Cuba	ın, Mexican	n, Puerto	Rican, etc.)		Black	k, White,	etc.
urs af tural"; al Exa		3 💢 Widowed		, A	Yes, Give ear or Dates.			1 🗌 Yes						Specify:	W	hite
72 ho n "nat	Completed		ecify only high	ent's Education est grade co	on mpleted)		(Gi	cedent's Usu ve kind of wo DO NOT us	ork done c	during most	t of work	ing	16b.	Kind of Bu	siness In	dustry
vithin jiene. er thai		Elementary/Seco	onday (0-12) 12	C	ollege (1-4 or !	5+)	me.			Mana	ager			Ca	fete	ria
filed \ al Hyg d othe	Be C	17. Father's Name (I		Last)						18. Mothe	er's Nam	e (First, Middle	e, Maider	n Surname,)	-
ald be Ment narker	욘	Grover C								Ro	sa N	lae Car	pent	er		
2 shou h and 7 is n traum	П	19a. Informant's Na					1	_				l Route Numb				•
and Healt		Shirley 20a. Method of Disp		-siste	r	20b. P		position (Na		a way		aithers Date		Location -		
age 1 ent of nt: If i		1 X Burial 2 4 ☐ Donation			oval from State	. C	emetery, c	rematory or	other plac			3/2012	1	nches	•	
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	"	21. Signature of Fur				1110	· Heb					≥Vol Fu				V21
88 2 5 5		Tapan	n Ms	Mille	aw	MO12	202	10 E.	Deer	Park	Dr	ive, Ga	ithe	ersbu	rg, l	MD 20877
		23a. Part 1. Enter the shock, or hear	rt failure. List	r complicatio only one cau	ns that caused se on each line	d the death e.	h. Do not e	nter the mod	de of dyin	g, such as	cardiac c	or respiratory a	ırrest,			Approximate Interval Between
Physician/ Medical	10	Immediate Cause (disease or conditio resulting in death)		a. <u>I</u>	neumon										- 1	Onset and Death
Examiner					Due to (or as Senile		,									
	iner	Sequentially list col if any, leading to im cause. Enter Under	nditions, mediate	b. —	Due to (or as										\dashv	
executed an and rial-transit	Examiner	Cause (Disease or in that initiated events	iinjury s	с	5 1 (\rightarrow	
e exercian a		resulting in death) L	Last		Due to (or as	a consequ	ience of):									
cate b physi s the k	Physician/Medica			d												
certifi nding use as	W _u	IF FEMALE: 23b. Was decedent	pregnant	23c. If	yes, outcome	of pregnar	ncy							23d. Date	e of delive	ery
death le atte ed for	sicia	in the past 12 r	months? ☑ No	4	Live Birth Pregnant a Unknown	t time of d	death 5	Other (s	pregnanc pe <i>cify)</i>	;y				Mon	ith	Day Year
at the	Phy	9 Unknown Part II. Other signifi				uit not reci	ulting in the	a underlying	cause di	en in Part I		00- 01-				
res this signed	d by	Tartii, Othor orgini	iodiii ooridiii	one contribu	ang to dout t	or not rose	annig in an	o anachymig	oddoc gri	on mir art i						ne cause of death?
requi been should	Completed											24a. Was				osy findings available
ne law e has age 2	l m											auto perf 1 Yes	yzgo	pi	rior to coi eath?	mpletion of cause of
ian: Ti rtifical rtor, pi	Be C	25. Was case referre	ed to medical				-		26. Pla	ace of Deat	th (Check		2 A J N	No 1	☐ Yes	2 L No
hysici his ce I direc	욘	1 ☐ Yes 2 💆	No No	Hospit	1 ☐ Inpati			ient 3 🗆 D	OA Othe	er: 4 🗌 Nu	ırsing Ho	me 5 K Res	idence	6 🗌 Other	(Specify)
ling P. After t funera	Certificate:	27. Manner of Death 1 💹 Natural	5 🗌 Pendi	ng	Ba. Date of inju (Month, Day	ry y, Year)	28b. Time injury	'	28c. Injury work	?		28d. Describe	how inju	ry occurred	d	
death ctor: y	lije Lije	2 Accident 3 Suicide	6 Could	not be	e. Place of Inju	ırv - At ho	me. farm. s	M street, factor		Yes 2 .	_	28f Location	(Street ar	nd Number	r or Rural	Route Number,
al or / s after I Dire		4 Homicide	detern	nined	building, etc	c. (Specify))	,	,,			City or To			Of Florar	riodie Nambei,
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicis puppleted filled in by the funeral director, page 2 should be detached for use as the but	Medical	29a. Certifier 1 (Check 2	A Certifying	Physician:	To the best of	my knowle	edge, deat	h occured at	the time,	, date and p	olace, an	d due to the ca	ause(s) a	ind manner	r as state	d. use(s) and manner stated
the H the F mplet	Me	only one) 3	☐ Certifying	Nurse Prac	ctioner: To the	best of my	knowledge	e, death occu	rred at the	e time, date	and plac	e, and due to the	he cause	(s) and mar	ner as sta	ated.
6.≥6.8H		29b. Signature and t	(1) 1	en		_		29	. License					ate signed		
		30. Name and addre		,	ted cause of d	eath (Item	23a) (Type	. Print)	D371	.42			Jar	nuary	24,	2012
		G. Colem							100,	Rock	cvill	Le, MD	2085	50		
Sta Registr		31. Date filed (Month	h, Day, Year) V 262	012	2. Registra	ar's Signati	ure L	us.								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ DOLORES PIVER-PERRY 2012 6:30 January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 108 Piver Lane Millington Queen Anne's Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Aug. 7 1930 1 M 2 F Months Days Hours Min. 81 Pennsylvania **Director** 170-24-4315 Usual Residence of Decedent 28a-f show 10a. State at 10c. City. Town or Location 10d. Inside City Limits Director Important: If item 27 is marked other than "natural", or items 23a or 28a-f si any injury or other traumatic event, the Medical Examiner must be notified. 1 Yes 2 X No MD Queen Anne's Millington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 108 Piver Lane 21651 U.S.A. within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after d Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or 1 Never Married 2 Married þ Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify. Specify. Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ann Kiker Joseph Francis McHenry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frank Piver (son) 204 Merganser Dr. Chestertown, MD. 21620 Baltimore, 20b. Place of Disposition (Name of Date Holy Sepulchre Cemetery 2/3/12 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Cheltenham, PA. Sion Galena Funeral Home of Stephen L. Schaech M00510 118 West Cross St. Galena, MD. 21635 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death s lock, or hart failure. List only one cause on each line.

Immediate C use (Final disease or condition Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner dequentiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that in lives a continuous cause) Due to (or as a consequence of) ysician and te burial-transit Exami or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical phy: nding p use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed Were autopsy findings available prior to completion of eause of death? 24a. Was an autopsy perform 2 🔃 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Desidence 6 Other (Specify) 1 🗌 Yes 2 100 ည 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending To the Hospital or Attendii within 24 hours after death. To the Funeral Director: Af 2 Accident 1 🔲 Yes 2 🗌 No Investigation Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature 29d. Date signed (Month, Day, Year)

State Registrar

Box 68760

P.O.

Records,

Division of Vital

DHMH 17 Rev 7/2009

32. Registrar's Signature

120 Speer Rd. Chestertown, MD. 21620

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Andrew S. Ferguson, M.D.

FEB 1 0 2012

31. Date filed (Month, Day, Year

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ EMEDITA OUINTOS Ε. Jänüary 23, 2012 6:30P. Medical 4a. Facility Name (if not institution, give street and number) Prince George's **Examiner** 4b. City, Town, or Location of Death Renaissance Gardens at Riderwood Village Silver Spring . Age (In yrs. la If Under 1 Year If Under 24 Hrs. **Funeral** last birthday, 8. Date of Birth 9. Birthplace (State or Foreign 043-32-9652 1 🗆 M 2 💢 F Mayoth 314, 1931 Days Hours Min. otatato Phillipines Director Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f shov injury or other traumatic event, the Medical Examiner must be notified at 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Maryland Prince George's Silver Spring 1 🗆 Yes 2 🔀 No 10f. Zip Code 10g. Citizen of What Country? Funeral 20904 3160 Gracefield Road, #RC1419 United States 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces?

1 Yes 2 No and Mental Hygiene. Black, White, etc. Page 1 and 2 should be filed within 72 hours after unent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or 2 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Asian If Yes, Give 3 X Widowed 4 □ Divorced Specify: Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 6+) Elementary/Seconday (0-12) Physician Private Practice -Medical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Felix M. Esguerra Endoso Leona 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2247 Richelieu Drive Vienna, Virginia 22182 19a. Informant's Name/Relationship (Type, Print) Mercedes Quintos-Gomez/daughter 20b. Place of Disposition (Name of cemetery, crematory or other p permit. Page 1 a
Department of H
Important: If ite 20c. Location - City or Town, State cemetery, crematory or other place)
Arlington National Cem. 1 X Burial 2 Cremation 3 Removal from State 2/1/2012 4 ☐ Donation 5 ☐ Other (Specify) Arlington, Virginia 21. Signature of Funeral Service Licepsee Donard V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 any plan Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Pnysician/ Ventricular Arrhythmia disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Atherosclerotic Cardiovascular Disease Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to tor as a consequence of attending physician and for use as the burial-transit b Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physician and that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 poinths?

1 Yes 2 No
9 Unknown 4 Pregnant at time of death 9 Unknown 5 Other (specify) Month Day Year certificate has been signed by the rector, page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hypertension; History of Cerebrovascular Disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No death? 1 Yes X No ☐ Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4X Nursing Home 5 Residence 6 Other (Specify) ဂ္ 1 ☐ Yes 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred X Natural 5 Pending 1 Tes 2 🗌 No Accident Investigation Completed filled in by the Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check To the within 2 only one cestifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signat le of cer 29d. Date signed (Month, Day, Year, D24035 January 24, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

E.S. Machado, M.D. 3110 Gracefield Road Silver Spring, Maryland 20904

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

JAN 26

			For State		State of Ma	aryland		artment of I <i>rtificate of I</i>		and Me	ental Hy	0	0.01	0 0	007
			Registrar 1. Decedent's Nam	ne (First, Middle, La	ast)		00	tincate or i	Jeani	1	2. Date of De	Reg. N	lo. /	3 Time	of Death
	Physicia Medic		John P	earse Q	uinlan						Month 1		Day Yea 4 2.0.1	r	
	Examin		4a. Facility Name (i	f not institution, giv	e street and number)			4b. City, Town, o	r Location	of Death			c. County of De		2 / E
					al Hospit			Berli					Worce		
	Funeral Director		5. Social Security N 118-24- Usual Residence of	5221	Sex 1X M 2 F	79	t birthday) Yrs.	If Under 1 Year Months Days	If Under Hours	Min.	B. Date of Bir Month, Da 14	rth 1 1 9	32	Birthplace (State Country)	e or Foreign
-	/land f show ed at	tor	10a. State	10b. County		10c. City,	Town or Lo	cation						10d. Inside	City Limits
-522	Man 28a- otifie	irec	MD	Worce	ester	00	cean	Pines						1 🗆 Y	∕es 2 ŒNo
74-6	h with the ns 23a or nust be r	Funeral Director	10e. Street and Nu	ail Dr.				10f. Zip Code 2181	. 1			10g. C	USA	Country?	
55N 118-21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. When them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status 1 ☐ Never Mari 3 ☐ Widowed	ried 2 X Married 4 Divorced	12. Was Decedent Every Armed Forces? 1			Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2X No	n, Mexicar	n, Puerto Ric	y Yes or No- can, etc.)	-	Black, Wh	nerican Indian, nite, etc. White	
Z -6 ;	2 hou "natu adical	plet	(Spe	15. Decedent's ecify only highest g	Education		16a. Dece	dent's Usual Occup	ation	et of warking		16b.	Kind of Busines		
55N 21215-(/ithin 7 iene. rr than the Me	Completed	Elementary/Sec		College (1-4 or 5-	+)	life. D	NOT use retired) Air Fo		n or working		G	overnm	ont	
ب ا	filed vall Hyg		17. Father's Name ((First, Middle, Last)			0.0.	7111 10		er's Name (F	irst, Middle,			enc	
1877	ld be Menta arkec atic e	မ	William	Quinla	n				Marg	garet	Case	∋y			
Maryland	shoun and 7 is m		19a. Informant's Na		** *	_		ng Address (Street							
ore, l	and 2 Healtl tem 2 ther t		Natalle 20a. Method of Disp		nlan / wi			ntail D	r.,						
Baltimore,	t. Page 1 tment of rtant: If ii		1 🔀 Burial 2 4 ☐ Donation	☐ Cremation 3 ☐ 5 ☐ Other (Spec	**	cen	netery, crer	natory or other place S Cemet			/12	Ηι	urlock	, MD	
2012 Bal	Depar Impo any ir once.		21. Signature of Fu	M 11/6	acheach	1	_ 1	Name and Addres N Name and Addres	iam	St.,	Berl	lin,	uneral , MD 2		
l .	hysician/ Medical		23a. Part 1 Enter t shock, or hea Immediate Cause (disease or condition resulting in death)	rt failure. List only ((Final	nplications that caused one cause on each line. a	stive	2 He	er the mode of dying			espiratory ar	rest,		Approxim Interval B Onset and	etween
E	Examiner	Ļ	Sequentially list co	nditions	b.	consequer	ice ot):								
	d ansit	Examiner	Sequentially list co if any, leading to in cause. Enter Under Cause (Disease or that initiated events	nying linjury	Due to (or as a	consequer	ice of):								
d X	physician and the burial-transit	edical Ex	resulting in death) I		Due to (or as a	consequen	ice of):								
	g phy as the	Medi			u										
Cords, P.O. Box 68	y the attending p		IF FEMALE: 23b. Was decedent in the past 12 r 1 ☐ Yes 2 ☐ 9 ☐ Unknown	months?	23c. If yes, outcome of 1 Live Birth 2 4 Pregnant at 9 Unknown	☐ Fetal d	eath 3	Ectopic pregnanc Other (specify)	у				23d. Date of d Month	lelivery Day	Year
	been signed by the should be detached	ਨੂ	Part II. Other signif	icant conditions o	contributing to death but	t not resulti	ng in the u	nderlying cause giv	en in Part I	l. 			use contribute		
カル、がルルーピー DOS Division of Vital Records, lal or Attending Physician: The law requires	s certificate has be lirector, page 2 sh	Completed	25. Was case referre								1 L Yes		prior to death?	utopsy findings completion of es 2 X No	
/ita	certif	ωĭ	examiner?		Hospital:				r:	th (Check on		<u> </u>			
JOVID on of Vi	eral d	e: 10	27. Manner of Death	1	1 Inpatier 28a. Date of injury	28	b. Time of	t 3 DOA 28c. Injury	4 ∐ Nu		5 Resid		6 Other (Spe	cify)	
o u	or; After he fun	icat Licat	1 Natural 2 Accident	5 Pending Investigation		Year)	injury	M 1 □	? Yes 2 🗀				, 00041704		
AH, Divisi	rs after de al Directo ed in by t	Il Certificate:	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could not be determined	28e. Place of Injury building, etc.		, farm, stre	et, factory, office		28f.	Location (S City or Tow		nd Number or R	ural Route Nurr	nber,
(ずはinlan _t Divisi To the Hospital or Att	within 24 hours after death. To the Funeral Director: After this certificate I completed filled in by the funeral director, page	Medical	(Check 2	Medical Exam	sician: To the best of m iner: On the basis of exa se Practioner: To the be	ımination ar	nd/or invest	gation, in my opinio	 n. death oc 	curred at the	time date a	nd place	and due to the	cause(s) and m	nanner stated.
3	o do		29b. Signature and t	title of certifier				29c. License)			te signed (Mon 24/20		
BA	15+1		Atitze	eshan A	completed cause of dea GH 9733 H	ith (Item 23	a) (Type, P	n'ue B	ler/11	n Mil) 2	18	11"		
	State Registra		31. Date filed (Month	JAN 26 2	2012 32. Registrar's	s Signature	1. 4	ake							

12-00750 Daniel Charles Ross

Ma-

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #29are Black Indelible Ink. Health and Mental Hygiene

			I- For State Control of Department of Treatment eg. No.	1301	
Physical Ex			1. Decedent's Name (First, Middle,Last)	2. Date of Death Month Day Year January 26, 2012 3. Time of 0846	
·joai Lx			Danie1 Charles Ross 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Deat	th 4c. County of Death	
			St. Mary's Hospital Leonardtown	St. Mary's	
Fune Direc			5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hr 3 47-42-5775 1 M 2 F 62 Yrs. Hours Mi	rs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (Sta Foreign Country) I1	
1	ì	-	Usual Residence of Decedent 10a, State 10b, County 10c, City, Town or Location	10d. Inside	e City Limits
	E	إ	Maryland St. Mary's Lexington Park	1 Ye	s 2 X No
farylar	be notified at once.	Director	10e. Street and Number 10f. Zip Code	10g. Citizen of What Country?	
the N	otifie		45725 Park Place 20653	United States	
5-0036 led within 72 hours after death with the Maryland tygene.	f be n	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 1 Never Married 2 Married 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Substitution of the Status	Specify Yes or No- to Rican, etc.) 14. Race - American Indian, White, etc.	васк,
ter dea	5 1		1½ Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify:	Specify: White	
urs aft	a in a	ē Š	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of during most of working life. DO NOT use re	f work done 16b. Kind of Business/Industry	
72 ho	1 3 1 3 1 3 1 3 1 3 1 3 1 3 1 3 1 3 1 3	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)		
21215-0036 uld be filed within 7 Mental Hygiene.	Media	E	4 Master Sargent	United States A	rmy
filed al Hyg	it B	BeC	17.1 attlet 3 Marie (First, Middle, Eddy)	Lorraine Burgess	
D 212 should be and Menta	E cve	10	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or	r Rural Route Number, City or Town, State, Zip Code)	
and 2 shored	umati		Sujinda M. Ross - Spouse 45725 Park Place, Lex	ington Park, Maryland 20 Date 20c. Location - City or Town, State	653
s l anof Heal	tant: 11 nem 2/1 is marked officer toals "natural"; or other traumatic event, the Medical Examiner		20a. Method of Disposition 1	2-08-2012 Charlotte Hall	MD
Baltimore, permit. Pages 1 ar Department of He	or of			108/12 Arlington, Virg	
Ball Sermit Depart				rinsfield Funeral Home F	
Physic	_		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac	oad, Leonardtown, Mary1a	nate Interval n Onset and
/Medi	cal		failure. List only one cause on each line. Immediate Cause (Final disease a. Hypertensive Atherosclerotic Cardiovascular Disease		Death
Exami	nei		or condition resulting in death) Due to (or as a consequence of):		
	ł	P	Sequentially list conditions, if eny, leading to immediate Due to (or as a consequence of):		
		Examiner	cause. Enter Underlying Cause (Disease or injury that initiated (Disease or injury that initiated Due to (or as a consequence of):		
ted	unsit	Exa	events resulting in death) Last Due to (or as a consequence or). d.		
8	ial - tran	Medical	UNPENDED AMENDED		
760,	physic he bur	Med	IF FEMALE: 23c. If yes, outcome of pregnancy	23d. Date of delivery	Vees
Box 687 death certifica	e attending phy for use as the	Physician/I	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnant at time of death 5 Other (Specify)	nancy Month Day	Year
death G	d for u	ysi	1 Yes 2 No 9 Unknown		
i the	ed by letache	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause	_
of Vital Records, P.O. og Physician: The law requires that the	n signed Id be detz	edt	chronic alcoholism	24a, Was an 24b, Were autopsy finding	Acres many
90.	as bec	Completed	<u> </u>	autopsy prior to completionperformed? death?	of cause of
The	ficate , page	Con	25. Was case referred to medical 26. Place of Death (Chec		No No
	s certi	Be	examiner? Hospital: 4 Insertinat: 3 ER/Outpotingt: 3 DOA Other Nurs	sing Home 5 Residence 6 Other:	
S Phys	iter thi	은 -:	1 Yes 2 No Part Part Part 2 Yes 2 No Part Part Part 2 Yes 2 No Part Part Part Part Part Part Part Part	28d. Describe how injury occurred	
on endin	the fire	ıtior			
Division tal or Attendu	in by	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc.	28f. Location (Street and Number or Rural Route I or Town, State)	Number, City
spital hours	filled	Cer	4 Homicide determined (Specify) 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, as	and the ball to the second of	
ihe Ho in 24 l	To the Funeral Director: completely filled in by the	ical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred	ind due to the cause(s) and manner as stated. d at the time, date and place, and due to the cause(s)	
To 1	Com	Medical	and manner stated. 29b. Signature and title of certifier 29c. License number	29d. Date signed (Month, Day, Ye	
•				January 27, 2012	
1		1	Name and address of person who completed caus death (Item 1/a)		
t por	2		Theodore M. King, Jr., MD. Assistant Medical Examiner 900 W. Baltimore Street,	Baltimore, MD 21223	
	e	tate	31. Date filed (Month, Day, Year) 1AN 3 1 2012 32. Registrar's Signature		

DHMH 17 Rev 1/2001 OCME 2006 ORIGINAL

		Please Type or Pri			_	_	ible.
		1 - State Registrar		artment of Health an tificate of Death	u Mentai ny	gierie Reg. No. 2	112 03874
	\$	Decedent's Name (First, Middle, Last)			2. Date of De	ath	3. Time of Death
Physic Med		Mildred Helen Rice			Month 01		2012 5:16 P M
Exam	iner	4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Location of D		4c. County	
Funera		29858	e (In yrs. last birthday)	Mechanicsville If Under 1 Year If Under 24 I	Hrs. 8. Date of Bir	St. Ma	9. Birthplace (State or Foreign
Directo			76 Yrs.	Months Days Hours N	Min. (Month, Da 09/09/	· · · ·	Rochester, NY
and show	٥	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Loc	cation	109/09/	1933	10d. Inside City Limits
Maryli 28a-f	Director	MD St. Mary's	Mechanics	ville			1 ☐ Yes 2 X No
th the	a D	10e, Street and Number		10f. Zip Code		10g. Citizen of V	Vhat Country?
eth wi	Funeral	29858 Coolidge Drive 11. Marital Status 12. Was Decedent	Ever in U.S. 13. V	20659 Vas Decedent of Hispanic Origin?	(Specify Yes or No-	USA 14 Bace	e - American Indian.
ire, Maryland 21215-0036 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	þ	1 ☐ Never Married 2 ☐ Married 3 ▼ Widowed 4 ☐ Divorced Armed Forces? 1 ☐ Yes 2 ▼ If Yes, Give Year or Dates.	No If	f Yes, specify Cuban, Mexican, Pu	uerto Rican, etc.)		k, White, etc.
15-C	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give k	lent's Usual Occupation kind of work done during most of	working	16b. Kind of Bu	siness/Industry
vithin / iene.	Con	Elementary/Secondary (0-12) College (1-4 or s	O+)	O NOT use retired) oll Supervisor		Departme	ent of Defense
filed wall Hyg	Be	17. Father's Name (First, Middle, Last)		-	Name (First, Middle,	Maiden Surname)
ylar	은	Fredrick George Deil		Anne	Mildred	Burke I	eil
Maryland 2 should be filed th and Mental Hy 27 is marked out traumatic eveni		19a. Informant's Name/Relationship (Type, Print)	1	g Address (Street and Number or			tate, Zip Code)
and and the Healt tem 2		Joanne Davenport / Daughter 20a. Method of Disposition	20b. Place of Dispos		DPO AP	96521	City or Town, State
mol		1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	cemetery, crem	natory or other place) ion Cemetery 02		Clinton	
Baltimore, Mapermit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau			00817 22		rinsfield	-Echols	Funeral Home P.
Ox 68760 The certificate be executed attending physician and attending physician and for use as the burial-transit	Examiner	Sequentially list conditions, if any, reading to humedrate cause. Enter Underlying Cause (Disease or injury that initiated events c.	a consequence of):	oti Carole	irascul	4 cho	Onset and Death
a ge and before	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown 1 ☐ Uve Birth 1 ☐ Pregnant a 9 ☐ Unknown	2 Fetal death 3 E	Ectopic pregnancy Other (specify)		23d. Dat	e of delivery hth Day Year
ords, P.O. v requires that the s been signed by t should be detacl	b	Part II. Other significant conditions contributing to death b	out not resulting in the ur	nderlying cause given in Part I.			bute to the cause of death? 3 Probably 4 Unknown
Records, The law requires ate has been sig	Completed				24a. Was autop perfo 1 ☐ Yes	osy p rmed? d	Vere autopsy findings available rior to completion of cause of eath?
of Vital Re ng Physician: The ter this certificate neral director, pag	Be	25. Was case referred to medical examiner?		26. Place of Death (C		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
of V Phys r this eral di	은 ::	1 Yes 2 No No No No No No No No No No No No No	ent 2 ER/Outpatien ry 28b. Time of	t 3 DOA Ourer 4 Nursin	g Home 5 Resid	dence 6 Othe	
on C anding ath. r: Afte	icate	1 Natural 5 Pending (Month, Da. 2 Accident Investigation	v, Year) injury	work? M 1 ☐ Yes 2 ☐ No	EGG. BOOMBO	ove injury occurre	
Division tal or Attendin rs after death. al Director: Affeed in by the ful	Il Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury building, etc.	ury - At home, farm, stre	et, factory, office	28f. Location (S City or Tow		r or Rural Route Number,
Division of Vital To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director,	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of 2 Medical Examiner: On the basis of e 3 Certifying Nurse Practitioner: To the	xamination and/or investi	igation, in my opinion, death occurr death occurred at the time, date ar	red at the time, date a	nd place, and due	to the cause(s) and manner stated.
North North		29b. Signature and title of certifier	0	29c. License number			(Month, Day, Year)
		20. Name and address of parent who completed ourse of	eath /Item 22a) (Time D	D1428	5	1 - L	7-12
10) prine		30. Name and address of person who completed cause of d William D. Boyd, II M.D.		Lookout Road,	Leonardto	own, MD	20650
	ate rar		ar's Signature				
DHMH 17 Rev 06	-2011						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 03875 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Robinson Physician/ Dabney Vance Month Day **14.** 6:59p M 2012 January Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death

District Heights 4c. County of Death Prince Georges Halleck Street 7106 If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Washington DC 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** 578-74-3377 55 Yrs. Months Days 1 🕱 M 2 🗆 F **Director** 1956 July 10, Usual Residence of Decedent 28a-f show 10a. State 10b. County with the Maryland notified at 10c. City, Town or Location 10d. Inside City Limits Director District Heights MD Prince Georges 1 🗗 Yes 2 🗌 No 10f. Zip Code **20747** 10e. Street and Number ō 10g. Citizen of What Country? Examiner must be Funeral 23a 7106 Halleck Street United States items (72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc ö 2 1 Never Married 2 Married Baltimore, Maryland 21215-0036 African If Yes, Give Year or Dates 1 ☐ Yes 2 🖾 No Specify: "natural", Specify. 3 Widowed 4 X Divorced Completed A merican the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry than life. DO NOT Elementary/Seconday (0-12) College (1-4 or 5+) **2yrs** Metro Access Driver and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) **Luther D. Robinson** 18. Mother's Name (First, Middle, Maiden Surname) **Betty**Boyd မ and 2 should be Health and Ment 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2017 Spruce Drive, NW, Washington DC 20012 19a. Informant's Name/Relationship (Type, Print) Department of Health ar Important: If item 27 is any injury or other trauonce. Betty B. Robinson / mother 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Page 1 cemetery, crematory or other place) 1 🗆 Burial 2 🔀 Cremation 3 🗀 Removal from State 1/18/2012 Beltsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 21. Signature of 22. Name and Address of Facility McGuire Funeral Service, Inc. 10 7400 Georgia Avenue, NW, Washington DC 20012 w 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ Atherosclerotic Cardiovascular Heart Disease disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): cause. Enter Ungeriving , alians, or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events and Due to (or as a consequence of): resulting in death) Last burialphysician Physician/Medical Division of Vital Records, P.O. Box 68760 the attending IF FEMALE nse 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No for Day Pregnant at time of death be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ื Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy perform certificate 2 🔀 No 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 St Residence 6 Other (Specify) 1 X Yes ည 2 No 1 Inpatient 2 I ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After 1 ื Natural injury 5 Pending work? s after death. 2 No ☐ Accident the f Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) upleted filled in by 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Hospital 24 hours a Funeral I Medical

State Registrar

within 24
To the F
comple

29a. Certifier

29b. Signature and title of certifier

Date filed (Month, Day, Year)

9

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar 03876 Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Ruth Rosenblum 2012 10°, 7:21 P M January Medical 4a. Facility Name (if not institution, give street and number) o. City, Town, or Location of Death **Bethesda** 4c. County of Death **Examiner** Suburban Hospital Montgomery Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 052-12-7371 **Director** 1 □ M 2 😿 F 06/30/1920 New York 91 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Rockville 1 Yes 2 No MD Montgomery 10f. Zip Code 10g. Citizen of What Country? United States Funeral 20852 6111 Montrose Road Apt. 1019 iral", or items? within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. ori Armed Forces Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify. 27 is marked other than "natural", traumatic event, the Medical Exal 3 X Widowed 4 Divorced Specify Completed White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry refiled win. (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) th and Mental h ပ္ Anna Goldbereg Samuel Leider 19a. Informant's Name/Relationship (*Type, Print*)

Ronald Rosenblum / Son 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 110 East End Avenue # 14J New York, NY 10028 1 and 2 s of Health item 27 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 Department of I Important: If it any injury or o ŏ 1 🗷 Burial 2 🗌 Cremation 3 🔀 Removal from State 4 Donation 5 Other (Specify) Star Memorial Gardens 1/15/2012 North Lauderdale, FL of Funeral Service Lie 22. Name and Address of Facility ${f Joseph~Gawler's~Sons~Inc.}$ 5130 Wisconsin Ave. NW Washington, DC 20016 23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one caus Pneumonia Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sepsis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) and 2 Hospital or Attending Physician: The law requires that the death certificate be executed Hypox1a Cause Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a Physician/Medical Division of Vital Records, P.O. Box 68760 d. 23c. If yes, outcome of oregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 X No Month Dav Year Pregnant at time of death the Unknown g 🗌 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Hypertensive Cardiac Disease, Atrial Fibrillation 1 Yes 2 No 3 Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed this certificate has page 2 🗌 No Yes 2 X No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospita Other: 2 X No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA ဂ္ 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work?
1 Yes 2 No 28b. Time of 28d. Describe how injury occurred Certificate: After 1 🔀 Natural 5 Pending thin 24 hours after death.

the Funeral Director: A mpletely filled in by the fi M 2 Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Xertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2. 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) 1/10/2012 D60117 - MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Eric Park MD 8600 Old Georgetown Road Bethesda, MD 20814

			For State Registrar		State	of Mary	land / Depa	artmen <i>tificat</i>			and M		_	2012)	038	377
			Registrar 1. Decedent's Name (First)	, Middle, Las	st)		Cer	uncau	e OI D	eatti		2. Date of De	Reg. No.	2016	_	3. Time of	Death
	Physicia Medic		Mildred	B. R	iggs							January	y 1 8	· 201		10:00	
	Examin		4a. Facility Name (if not ins			ımber)				Location o	of Death			County of Dea			
	Funeral		403 Circle 5. Social Security Number			7. Age (In	yrs. last birthday)		oma]	If Under	24 Hrs.	8. Date of Bir		ntgome		e (State or	Foreign
	Director		577 - 34 - 6140		□м 2 Ж F	89		Months	Days	Hours	Min.	ug. 24	y, Year) 92	22 Sou	t'h'	Carol	lina
	nd how at	=	Usual Residence of Deced 10a. State 10b.	dent County		100	c. City, Town or Lo	cation							Ind	Inside Cit	v Limits
	Maryla :8a-f s tified	rect	MD Mo	ntgome	ry		Takoma								1	1 X Yes	
	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If teem Z7 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral Director	10e. Street and Number					10f. Zip						en of What C			
:	ath wil	nuer	403 Circle	Avenue		cedent Ever i	niis 13 V		912	spanic Orio	nin? (Snec	cify Yes or No-		ted St			
ဋ	fter de , or ite amine	줅	1 Never Married 2	☐ Married	Armed F	orces?	1	Yes, spec	ify Cubar	n, Mexican	, Puerto F	Rican, etc.)		4. Race - Am Black, Whi Afr			
9500-61212	ours at rtural" al Exa	Completed	3 Widowed 4 🛭 D		If Yes, G Year or I	ive Dates.		☐ Yes					S	inecity:	ric		
ပ် ု	א 72 ה an "na Medio	m p	(Specify on		ade complete		16a. Deced (Give life. D	lent's Usua aind of wor O NOT use	k done di	ition uring most	of workin	g		d of Business			
7	l withii ygiene her th t, the				5+	(1-4 or 5+)	Ехес	ıtive	Ass	istan	t		Fede	ral Co	urt	8	
yland	oe filec ental H ced otl	To Be	17. Father's Name (First, M									(First, Middle,		urname)			
ary:	nould the mark simark		George By 19a. Informant's Name/Re		/pe, Print)		19b. Mailir	a Address	(Street a			Route Numbe		own State 7	in Code	a)	
, Mar	nd 2 st ealth a n 27 is er tra		Camille Mos	1ey - I	aughte	er						Washing	-			012	
baitimore,	ge 1 an nt of Ho : If iten or oth		20a. Method of Disposition 1 X Burial 2 ☐ Crei		Removal from		0b. Place of Dispo cemetery, cren	sition (Nan natory or o	ne of ther place			ate		cation - City o			
ונוש	nit. Pag artmen ortant injury		4 Donation 5 0			Ma	aryland 1					2012 uire F					
Ö	Impe any any		Synne	Im	Ju	re						N.W. I				• Inc	
			23a. Part 1. Enter the dise shock, or heart failure	ease, or comp e. List only o	olications that	t caused the	death. Do not ente	r the mode	e of dying	, such as	cardiac or	respiratory an	rest,		Ap	proximate erval Betw	e veen
P	h, sician/		Immediate Cause (Final disease or condition	_		Brain	Tumor								6	set and D mont	eath hs
End !	Medical Examiner		resulting in death)	ſ	Due to	o (or as a con	sequence of):										
	-0	iner	Sequentially list condition if any, leading to immediate cause. Enter Underlying	s, te	b. Due to	o (or as a con	sequence of):								-		
poti	and transit	xam	Cause (Disease or linjury that initiated events	1	C. Due to	. (04 05 0 0 0									<u> </u>		
) he ex	cate be executed physician and transit transit	dical Examiner	resulting in death) Last	L	. Due to	Olas a con	sequence of):										
ַבָּילָ בַּילָי	incate ig phys as the	Medi	IE EEMALE	_	d							_					
Š į	tri cerr tendin or use	ian/f	IF FEMALE: 23b. Was decedent pregna in the past 12 months	alle T		e Birth 2 🗌	Fetal death 3	Ectopic p		/			20	3d. Date of de			
ם ק	re dear	Physician/Me	1 ☐ Yes 2 🔼 No 9 ☐ Unknown		4 ∐ Pre 9 ☐ Uni	gnant at time known	e of death 5 L	Other (sp	ecify)					Month	Day	⁄ Y∈	ear
֝֞֞֝֓֞֝֓֞֝֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓	natin	by Pr	Part II. Other significant of				t resulting in the u	nderlying a	ause give	en i n Part I		23e. Did to	obacco use	e contribute t	o the ca	use of de	ath?
S C	en sig	ted I	Coronary A	Artery	Disea	se						1 🗆 '	Yes 2	No 3 □ F	robably	/ 4X □ U	Inknown
	has be	Completed	Hypertensi	Lon								24a. Was autor	osy			indings avetion of ca	
ב הלים הלים	ficate or, pag		Chronic Ki 25. Was case referred to m		Diseas	e			00 8	(1)		1 🗆 Yes	rmed? 24 No	death?	s 2 🛭	No	-
VILC	ysicia is cert direct	To Be	examiner? 1 Yes 2 No		Hospital:	Inpatient 2	2 ☐ ER/Outpatien	t 3 🗀 DO	Other	ce of Deat		o <i>niy one)</i> ne 5 X Resid	lence 6	Other (Spe	nifu)		
5 6	ing ru		27. Manner of Death 1 X Natural 5	Pending	28a. Date	e of injury nth, Day, Yea	28b. Time of		Bc. Injury work?	at		3d. Describe h			511 97		
To the	death ctor: A	Certificate:	2 Accident 3 Suicide 6	Investigation Could not be		o of Injune . /	At home, farm, stre	M et factor		res 2 🗌		06 1 16 16	N	Mt. D			
	s after	_	4 ∐ Homicide	determined		ding, etc. (Sp.		et, ractory,	onice		2	8f. Location (S City or Tow		Number or Ki	irai Rou	te Numbe	er,
Hospit	To the hospital or Attention Priysical: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burian transit.	Medical	(Check 2 L Me	dical Exami	ner : On the ba	asis of examir	nowledge, death o nation and/or invest	gation, in n	ny opinion	n, death oc	curred at the	he time, date a	nd place, a	and due to the	cause(s) and man	ner stated.
To the	within To the	Σ	only one) 3 L Ce 29b. Signature and title of		e Practioner	: To the best of	of my knowledge, d		red at the License		and place,			and manner as signed (Mont		Year)	
			Bally						#D28	656			Janua	ry 17	20	12	
			30. Name and address of p						Ste.	130,	, Roc	kville	, MD	20850)		
	Ravi Passi, M.D. 15245 Shady Grove Road, Ste. 130, Rockville, MD 20850 State Registrar 31. Date filed (Month, Day, Year) 32/ Registrar's Signature																

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

			Plea							-		_	le.	
		For State Registrar		State of	iviaryiai					vientai Hy	giene Reg. No	20	12	03878
	Ţ,		e (First, Middle	e, Last)			-			2. Date of De	ath		1	3. Time of Death
						GANG	00			JAN.	24	ž, 2Ŏ	12	9:45 A ^M
Examin	er				er)							. County of		70D 27 ! 6
State Physician Physicia					8. Date of Bir	th	9	. Birthpl	EORGE 'S ace (State or Foreign					
				1 X M 2 □ F	83	3 `	Yrs.	Months Days	Hours Min.	APR. 1	6,19	28	Countr	YORK
nd how at	ř				10c. C	ty, Town	or Loc	eation					10	0d. Inside City Limits
// Aaryla 8a-f s tified	recto	MD.	PRINC	CE GEORGE'S	,		R	TVERDALE						1 X Yes 2 No
a or 2 be no	اقا								*		10g. Cit	tizen of Wha	at Count	ry?
th with ms 23 must	ıner		RIVERD			0	Loui				Т	U.S.		
or iter			ied 2 ☐ Mar	Armed Ford	es?		13. V	Vas Decedent of H Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto	ecity Yes or No- Rican, etc.)		14. Race - Black,	America White, el	
ırs afte ıral", I Exar	ed b			If Yes, Give	KORE	AN	1	☐ Yes 2 ☐XNo	Specify:			Specify:	WH]	ITE
72 hou "natu edica	plet	(Spe					(Give k	and of work done of	during most of work	king	16b. K	ind of Busir	ness Indu	ustry
iene. r thar the M	Con	Elementary/Seco	onday (0-12)		or 5+)					ER		NAVY	DEI	PARTMENT
filed val Hyg		17. Father's Name (F	First, Middle, l	Last)				2 110 0 011221			Maiden		211	
Ment Ment narked	₽				GANO	_			CA	RMELA	Τ	OTARO		
2 shouth and the and the and the and the and traum														ode)
f Healt item a)/SISTER		Place of	Dispos	sition (Name of		VERDALE Date		ocation - Ci		vn, State
Page nent o ant: If iry or					riate				· .	2012	BR	ENTWO	OD,	MD.
ermit. epartr nporta ny inju		21. Signature of Fur	neral Service I	Licensee	1									
0 □ = @ O		220 Part 1 Enter ti	be disease or	complications that or			1 5	801 CLEV	ELAND AVE	., RIVE	RDAL	E, MD	20	0737
Dhusisian/		shock, or hear	rt failure. List o	only one cause on eac	h line.			i the mode of dylin	g, such as cardiac	or respiratory ar	rest,			Approximate Interval Between Onset and Death
Medical			in										+	JNKNOWN
Examiner	_	Sequentially list cor	nditions.	b. ———										
D st 2	mine	if any, leading to im cause. Enter Under	nmediate rlying	Due to (o	r as a consec	uence o	f):							
xecution and al-trar		that initiated events	S	c. Due to (o	r as a consec	uence o	f):						+	
te be e nysicia ne buri	dical			d									\perp	
ertifica ding pl	/Me			23c If yes outc	ome of prean	ancv								
eath o	iciar	in the past 12 r	months?	1 Live B	irth 2 🗌 Fet ant at time of	al death			у			23d. Date of Month		y Day Year
t the d by the tached	Phys	9 🗌 Unknown									l.			
es tha signed I be de	þ	Part II. Other signifi	icant condition	ons contributing to de	ath but not re	sulting ir	the ur	nderlying cause giv	ven in Part I.					e cause of death?
requir been should	lete									24a. Was				sv findings available
he law te has age 2	omp									auto	psy orm <u>ed</u> ?	prio dea	r to com	pletion of cause of
ian: T			ed to medical					26. PI	ace of Death (Chec	1 🗆 Yes k only one)	2.10.1 No		res 2	: LI NO
Physic this ce al dire	유	1 Yes 2 2 27. Manner of Death		1 🗆 1r				t 3 □ DOA	4 ☐ Nursing H				Specify)	
ding I th. After funer	Certificate:	1X Natural 2 Accident	5 Pendir	19	, Day, Year)	28b. Ti in	ju r y	28c. Injun work M 1 🗆		28d. Describe I	now injury	y occurred		
r Atter er dea rector by the	ertifi	3 Suicide 4 Homicide	6 Could	not be 28e. Place of	f Injury - At h		m, stre	et, factory, office		28f. Location (S			r Rural F	Route Number,
oital or urs aft rral Dii			32											
e Hosp 24 ho e Fune leted f	Medical	(Check 2	Medical E	g Physician: To the bea Examiner: On the basis g Nurse Practioner: To	of examination	n and/or	investi	igation, in my opinio	on, death occurred a	t the time, date a	and place	, and due to	the caus	se(s) and manner stated.
To th To th comp	2	29b. Signature and t			Λ	,, , , , , , , , , , , , , , , , , , , ,		29c. License			29d. Dat	te signed (N	onth, Da	
941		•	July 1	yyura (11)					5001		01	25-2	012	
				who completed cause					OTIDE CIT	TE 200	TAT	000 3	m '	2077/
Stat	e	DR. JAY 31. Date filed (Monti	H LI h, Day Year)	IPPMAN, M.I) . gistrar's Signa	ture	<u> </u>	BASIL C	OURT, SUI	.IE ZUU,	LAN	KGU, M	IJ• <u>`</u>	<u> 20774</u>
Registra	ar	JA	NAP	CUIZ Center	un f	1. 6	Tar.							

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 Miriam В. Reed January 2:05 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 11401 Kenton Montgomery Drive Silver Spring Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** Days 214-03-9196 **Director** 1 🗆 M 2 🕮 F 94 MD March 15, 1917 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location with the Maryland 10d. Inside City Limits Examiner must be notified at Director 1 Yes 2 XNo MDMontgomery Silver Spring 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 11401 Kenton Drive 20902 USA permit. Page 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, White 1 Never Married 2 Married 'natural", or by 1 Yes 2 If Yes, Give Year or Dates Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify. Completed 3 X Widowed 4 Divorced and Mental Hygiene.
is marked other than "natur 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Lamar Baker traumatic Caroline Osterkamp 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trauonce. Gloria A. Reed/Daughter 11401 Kenton Drive, Silver Spring, MD 20902 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) Jan. 4 ☐ Donation 5 ☐ Other (Specify) Parklawn Memorial Park 20īž Rockville, MD Signature of Francis J. Collins Funeral Home 500 University Blvd. W., Silver Inc. Spring, MD 20901 Jalin 23a. Part f. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Alzheimer's Dementia disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): for use as the buria attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Day Pregnant at time of death been signed by the a should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 24 hours after death. Funeral Director: After this certificate has director, page 2 autopsy performed 2 🗌 No Yes 2 X N 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner's Other: 4 Nursing Home 5 M Residence 6 Other (Specify) 1 ☐ Yes 2 🛂 No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA letely filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 \square Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier *Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check within 2 To the Etripping Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) D34032 January 24, 2012 of person who completed cause of death (Item 23a) (Type, Print) 30. Name and addres Jeanne Asher, MD 3720 Farragut Avenue, Kensington, MD 20895 Day, Year) 32. Registrar's Signature State 26 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 1 3. Time of Death Physician/ 2012 David Rickards 5:22 P^{M} Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Atlantic General Hospital Berlin Worcester 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 | F Hours Min, Days (Month, Day, Year) 5 218-64-5696 Yrs Country) **Director** 46 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at ones. 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1X Yes 2 No MD Worcester Ocean City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Saint Louis Ave., Unit 8 21842 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐XNo If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status þ 1 X Never Married 2 Married Maryland 21215-0036 1 Yes 2 XNo Specify: Completed 3 - Widowed 4 - Divorced Specify white 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) GED Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Walter A. Rickards Mary Carole Block 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1815 Quebec St., Severn, MD 21144 Nancy Bright / Sister Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 \square Burial 2X Cremation 3 \square Removal from State 4 ☐ Donation 5 ☐ Other (Specify) State Crem. 1/26/2012 Millsboro, DE 21. Signature of Funeral Pervice License 22. Name and Address of Facility Burbage Funeral Home hetray 108 William St., Berlin, MD 21811 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition neumonia Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to in inculate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 XYes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 XNo 1 Yes 2 No Vital the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 🔀 No Certificate: To 1 🗌 Yes Other: 1 Npatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending injury Division within 24 hours after death. To the Funeral Director: Af 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 🗌 Homicide City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 10064120 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Drive Atif Zeenhah Dath 9733 Health way Drive Atit Zeerhan Berlin MD 21811.

BA 3 State

25/

S

غ

DHMH 17 Rev 7/2009

Registrar

31. Date filed (Month, Day, Year)

JAN 26

32. Registrar's Signature

			State of Maryland / Dep		lental Hyg	jiene	0 00001
				rtificate of Death		Reg. No. 201	2 03881
	Physicia	in/	1. Decedent's Name (First, Middle, Last)	D1	2. Date of Deat Month	Day Ye	3. Time of Death
	Medic Examir		Ann WEISS 4a. Facility Name (if not institution, give street and number)	Rommel 4b. City, Town, or Location of Death	January	4c. County of D	
	LAGIIII	ICI	733 ANNATANA DRIVE	FOREST HILL		HARFOR	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs.	8. Date of Birth	g.	Birthplace (State or Foreign
	Director		218-22-6968 1 □ M 2 🗓 F 85 Yrs.	Monard Bay From Min.	JAN. 2,	1927 WE	ST VIRGINIA
	and show	ē	10a. State 10b. County 10c. City, Town or Le	ocation			10d. Inside City Limits
	Mary 28a-f otifie	irec	MARYLAND WORCESTER OCEAN	PINES			1 X Yes 2 No
	th the 3a or t be n	Funeral Director	10e. Street and Number	10f. Zip Code	1	10g. Citizen of What	: Country?
	ath wi	nne	40 CLUBHOUSE DRIVE 11. Marital Status 12. Was Decedent Ever in U.S. 13.	21811 Was Decedent of Hispanic Origin? (Spe	cify Yes or No.	USA	
တ္	ter de , or ita mine	by F	1 Never Married 2 Married 1 Yes 2 No	If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)		merican Indian, /hite, etc.
000	ours af tural" al Exa	ted	Year or Dates.	1 ☐ Yes 2 🗶 No Specify:		Specify:	WHITE
7	72 ho in "na Medic	Completed	(Specify only highest grade completed) (Give	edent's Usual Occupation skind of work done during most of working DO NOT use retired)	ng	16b. Kind of Busine	ess/Industry
212	within 72 hours after death with the Maryland glene. er than "natural", or items 23a or 28a-f sho , the Medical Examiner must be notified at		College (1-4 or 5+)	OKKEEPER		CATHOLIC	CHURCH
nd	e filed had had had othe event,	To Be	17. Father's Name (First, Middle, Last)	18. Mother's Name			
Maryland 21215-0036	2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at		PAUL R. WEISS	MABEL		KELLEY	
Ma	sh ar h ar 7 is trau			ing Address (Street and Number or Rura ANNATANA DRIVE, FO			
ore,	t of Healt If item 2 or other		20a. Method of Disposition 20b. Place of Disp			20c. Location - City	
Baltimore,	. Page tment o tant: If jury or		The band E is distributed to in the first the state	VETERANS CEM 1/27	7/12	HURLOCK,	MARYLAND
Bai	permit. Page Department Important: I any injury or once.			2. Name and Address of Facility	ME CET	DVVITTE	DE 10075
			23a. Part 1. Enter the disease, or complications that caused the death. Do not ent	ASTINGS FUNERAL HO			Approximate
~ F	hysician/		shock, or heart failure. List only one cause on each fine. Immediate Cause (Final disease or condition Lun Cancer				Interval Between Onset and Death
	Medical Examiner		resulting in death) a. Due to (or as a consequence of):				
	-	Jer	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):				
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease on injury) that initiated events c.				
	ate be executed bhysician and the burial-fransit	al Ex	resulting in death) Last Due to (or as a consequence of):				
09/	cate be physic s the b	edical	d				
9	certificate nding physuse as the	In/M	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of	delivery
Rox	death he atter	Physician/Me	1 Yes 2 No 4 Pregnant at time of death 5	Ctopic pregnancy Other (specify)		Month	Day Year
	at the d by th		g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the i	underlying cause given in Part I	OOA Distant		to the constant of the the
a,	requires that the death certifica been signed by the attending pl should be detached for use as t	d by		and the second s			to the cause of death? Probably 4 🗆 Unknown
Ö	w requ	Completed			24a. Was an	24b. Were	autopsy findings available
Records,	The la ate ha page	Som			autopsy perform	ned? death	to completion of cause of 1? Yes 2 \sum No
Vital	ician: certific ector,	Be	25. Was case referred to medical examiner? Hospital:	26. Place of Death (Check	only one)		
OT O	Physical this carral dir	<u>و</u>	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie 27. Manner of Death 28a. Date of injury 28b. Time o	nt 3 DOA Other: 4 Nursing Hor	me 5 Resider	nce 6 Other (Sc	AUGHTER'S HOME
ם פיי	nding ath. :: After e fune	icate	1 ★ Natural 5 ☐ Pending (Month, Day, Year) 2 ☐ Accident Investigation	f 28c. Injury at work? M 1 □ Yes 2 □ No	8d. Describe hov	w injury occurred	
DIVISION	r Atter ter des rector by th	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, str building, etc. (Specify)	eet, factory, office			Rural Route Number,
5	pital o			4	City or Town,		
:	of the Pospital or Attending Physician: The law within 24 hours after death. To the Funeral Director After this certificate has I completely filled in by the funeral director, page 2 s	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death of the best of my knowledge, death of the best of my knowledge only one) 2 Medical Examiner: On the best of my knowledge of examination and/or investoring only one)	tigation, in my opinion, death occurred at t	the time, date and	place, and due to the	ne cause(s) and manner stated
	Vithir Comp	2	29b. Signature and title of certifier	29c. License number		d. Date signed (Mo	
	10		· Who chatiful MB	024356		January	23,2012
	UTO 1		30. Name and address of person who completed cause of death (Item 23a) (Type, F	Print) 9103 Frankler Rosedele		Juite 2 -1237	260
j	Stat	e	31. Date filed (Month, Day Year) 2012 3. Registrar's Signafire		-10 -	1-3/	
	Registra	r	UNINGU CUIZ KENGUE B. MAN				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 10a-c.e.f. per inf g924 2-21-12 yt. State of Maryland / Department of Health and Mental Hygiene 03883 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2012 Lawrence Martin Schadegg January 8:45 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 836 Runabout Loop Calvert Solomons 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs, last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours Min **Director** 475-44-0942 1 X M 2 🗆 F 67 Yrs 08/30/1944 California Usual Residence of Decedent 28a-f show 10b. County with the Maryland Director 10c. City, Town or Location 10d. Inside City Limits 0kanogan Washington notified **Omak** 1 🗌 Yes 2 🙀 No Maryland Galvert -Solomons 10e. Street and Number Ö 10f. Zip Code 10g. Citizen of What Country? pe I 223 Haley Creek Road 98841 Funeral 23a 20688 836 Runabout Loop United States Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, "natural", or ite Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White If Yes, Give Year or Dates 3 Widowed 4 Divorced 1 ☐ Yes 2X No Specify: Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) of Health and Mental Hygiene. Item 27 is marked other than other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Physicist Contractor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Alfred Henry Schadegg Rosetta Leona Reed 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jennifer Henkel - Daughter 24972 Cuckold Cove Way, Hollywood, Maryland 20636 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date t of ... TX Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place) permit. Page Department of Important: If any injury or Aloyisus Cemetery 02/01/2012 Leonardtown, Maryland 22. Name and Address of Facility Brinsfield Funeral Home P.A. 21. Signal Service Constitues Ci Kathleen A. Santivasci M00872 22955 Hollywood Road, Leonardtown, Maryland 20650 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician Lolo rectal C disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examine Due to (or as a consequence or). Cause (Disease or injury that initiated events resulting in death) Last attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Month signed by the at d be detached fo Pregnant at time of death Dav Year Yes 2 No 1 L Yes 2 L 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an the Hospital or Attending Physician: The law Jas autopsy nin 24 hours after death.

the Funeral Director: After this certificate h
npletely filled in by the funeral director, page performed death? 1 🗌 Yes 2 💽 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 2 No Other: 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural Accident 5 Pending 1 Yes 2 No Investigation Suicide 6 Could not be 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the F 3 Certifying Nurse Practition er: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 30 30. Name and address of p ompleted cause of death (Item 23a) (Type, Print) 30+1 Merrimac Ct, Prince Frederick, MI RMIL Kaymon Noble State JAN3 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 Barbara Sparks Ann 8:17 p.mM. Medical January 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 20500 Bowles Road Coltons Point St. Mary's **Funeral** Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign 8. Date of Birth Hours Min (Month, Day, Year, Director 1 □ M 2 🔏 F 214-60-1563 Usual Residence of Decedent 60 09/30/1951 Maryland or 28a-f show notified at with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 XNo Maryland St. Mary's Coltons Point 23a o. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral must 20626 20500 Bowles Road United States ral", or items 2 I Examiner mus death 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 2 X No Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 X No Specify: "natural" Completed 3 XWidowed 4 ☐ Divorced If Yes, Give Specify Year or Dates White Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working and Mental Hygiene. is marked other than life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) other traumatic event, the Housekeeper Housekeeping Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Majden Surname) 2 George Bernard Quade Helen Louise Knott 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a <u>Kimberley B. Bowles/Daughter</u> 20500 Bowles Road, Coltons Point, MD item 20a. Method of Disposition 20b. Place of Disposition (Name of Department of Important: If it any injury or o cemetery, crematory or other place) 1
Burial 2
Cremation 3
Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Brinsfield-Echols Cre 02/02/2012 | Charlotte Hall, MD 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 21. Signature of Funeral Service Licen Danielle Ward M01403 22955 Hollywood Road, Leonardtown, MD 20650 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition Approximate Interval Between Onset and Death Physician/ Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): that the death certificate be executed Due to (or as a consequence of): resulting in death) Last attending physician I for use as the buria Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy Month Pregnant at time of death Day Year 9 Unknow Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖼 nknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has performed Yes 2 death? certificate 1 ☐ Yes 2 ☐ No or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 140 Other: မှ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Deat 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1-Watural 5 Pending injury ours after death.

leral Director: Aff

filled in by the fu Suicide Investigation 1 Yes 2 No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined building, etc. (Specify) 24 hours Medical 29a. Certifier La Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certi

Registrar

31. Date filed (Month,

10) pml

63

Registrar's Signatur

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Stephenson January 2012 Anna Medical 4a. Facility Name (if not institution, give sireet and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Genesis HealthCare Severna Park If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** July 14, Days Hours Months 1 M 2 X , 1934 Germany 511-62-2871 77 Director Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director Anne Arundel Severna Park MD 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21146 310 Genesis Wav 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?
1 ☐ Yes 2 🛣 No
If Yes, Give þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Ith and Mental Hygiene. 27 is marked other than r traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Home Homemaker Be 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last, 2 Anton Peter Carolina Niebler 1 and 2 should be of Health and Ment 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trainonce. 541 Charington Drive, Severna Park, MD 21146 Trina Ellis / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State January 27, cemetery, crematory or other place, 1 X Burial 2 Cremation 3 Removal from State Parsons, Kansas Memorial Lawn Cemetery 2012 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Barranco & Sons, P.A. Severna Park Funeral Home 495 Ritchie Hwy, Severna Park, MD 21146 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ pertensive Cardiovascular Disease disease or condition Medical resulting in death) Examiner Senile Dementio Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Pregnant at time of death 2 No been signed by the should be detached 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Accident Cerebrovascular 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autops Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 2 🕅 No ၉ 1 Yes 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) 1 X Natural 5 Pending n 24 hours after death. e Funeral Director; Aft bleted filled in by the fur 1 Yes 2 No Accident M Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hos To the Fune completed fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

 P^{M}

3:30

9. Birthplace (State or Foreign

White

10d. Inside City Limits

Approximate Interval Between Onset and Death

Year

lears

Years

death? 1 Yes 2 No

January 23

CRNP

1 🗌 Yes 2 💢 No

State Registrar 6095

ORIGINAL

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Millie Jarrell

29c. License number

Elkridge

RO68482

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Marie Summers M. 2012 11:57 AM January Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City. Town, or Location of Death Collington Episcopal Lifecare Com. Mitchellville Prince George's 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2 🔽 F Maryland 213-46-9014 100 **Director** Sep. 1911 Usual Residence of Decedent 28a-f show 10a. State 10b. County notified at 10c. City, Town or Location 10d. Inside City Limits Director MD 1 Tes 2 No Prince George's Mitchellville 10e. Street and Number 10f. Zip Code ŏ 10g. Citizen of What Country? ed other than "natural", or items 23a or event, the Medical Examiner must be Funeral 10450 Lottsford Road, # 440 20721 USA 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: White Specify: 3 X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working and Mental Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Secretary Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Samuel A. Mudd II permit. Page 1 and 2 should be Department of Health and Meni Important: If item 27 is marke any injury or other traumatic voice. Claudine L. Burch 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) George Mace Summers/son 10048 Colebrook Avenue, Potomac, MD 20854 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) Burial 2 Cremation 3 Removal from State 4 Onation 5 Other (Specify) Resurrection Cemetery 1-27-2012 Clinton, Maryland 22 Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy., Bowie, MD 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ heimer disease or condition Medical resulting in death) to (or as a consequence of) Examiner failure to thrive if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): -transit LUVEUG and Due to (or as a consequence of -burialnding physician ause as the burial-Physician/Medical UVOARUIC that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Li record 3 Ectopic pregnancy
5 Other (specify) for in the past 12 months? Month 2 No 1 Yes 2 Unknown ed by the a Part II. Other, significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à カゴウ or Attending Physician: The law requires 1 ☐ Yes 2 🗖 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy perform death? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other မ 1 Inpatient 2 I ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this funeral (27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural work?
1 Yes 2 No 5 Pending within 24 hours after death.

To the Funeral Director: Af completed filled in by the fu Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 [Certifying Nurse Practioner: To the best of my knowledge, death occurr 29b. Signature and title of cert 29c. License number 049 2012 Upper Marilbovo ne and address of person who completed cause of death (Item 23a) (Type, Print) 50 uampaloup

State

31. Date filed (N

parks!

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 03887 For State Registrar Certificate of Death Rea No 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ 201 Jan. 3:10P M Benjamin Strong Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 4c. County of Death Largo MD Prince Georges Manor Care 600 Largo Rd. 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** NC 85 5 Director 245-22-3037 Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director MD Seat Pleasant Yes 2 No Prince Georges 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6801 Greig Street 20743 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? 12 Yes 2 No 1945 1 Never Married 2 Married Black, White, etc. þ hours after Maryland 21215-0036 1 Yes No Specify: Specify: Black If Yes Give 1948 3 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) 72 I Hygiene. other than " Elementary/Seconday (0-12) College (1-4 or 5+) should be filed within and Mental Hygien r is marked other th 12th Truck Driver Private Industry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Willie Strong Mary Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s f Health item 27 1319 29th St. SE #5 20020 Wash. DC Anthony T. Strong, Son other t Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ott Date cemetery, crematory or other place, 1 Burial 2 Cremation 3 Removal from State Chesapeake Crem. 1/19/2012Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Ligensee 22. Name and Address of Facility Latney's Funeral Home cc0278 3831 Georgia Ave. NW WDC 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Heart Failure Medical Due to (or as a consequence of) Examiner Chronic Kidney Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) requires that the death certificate be executed Cause (Disease or linjury <u>Diabetes Melitus</u> that initiated events resulting in death) Last attending physician for use as the burial Physician/Medical Chronic Pulmonary Disease Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death signed by the Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Diaphragmatic Lermia Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 😾 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law cate has autopsy performed? certificate 2 🗌 No 1 Yes Yes funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred After 5 Pending within 24 hours after death.
To the Funeral Director, Afte completed filled in by the fun Natural work 1 Yes 2 No Accident Investigation 6 Could not be 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 3 1/11/2012 30. Name and addre

State Registrar #B, Greenbelt, MD 20170

f person who completed cause of death (Item 23a) (Type, Print)

19

32. Registrar's Signature

	FOI	epartment of Health and Nertificate of Death						
Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) BERNARD MARTIN SWANN 4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	JANUARY	Day Year 23 2012 3. Time of Death 9:15 A M				
Funeral Director	3742 S. Leisure World Blvd. 5. Social Security Number 579-18-1117 State Factor Fact	Months Days Hours Min	8. Date of Birth (Month, Day Year APTII 20	ontgomery 9. Birthplace (State or Foreign Country) 1923 Washington, DC				
leath with the Maryland tems 23a or 28a-f show or must be notified at Funeral Director	10a. State 10b. County 10c. City, Town or	ver Spring 10f. Zip Code	10g.	10d. Inside City Limits 1 ☐ Yes 2 🖾 No Citizen of What Country?				
ter of in in in in in in in in in in in in in	3742 S. Leisure World Blvd. 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates. WW—II	20906 3. Was Decedent of Hispanic Origin? (Spit Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☒No Specify:	ecify Yes or No- Rican, etc.)	USA 14. Race - American Indian, Black, White, etc. Specify: White				
led within 72 hours at Hygiene. other than "natural" ent, the Medical Exe ent, the Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) 1 1 College (1-4 or 5+) Me of the complete of the control of the	ecedent's Usual Occupation live kind of work done during most of work a. DO NOT use retired) Chanic	A	Kind of Business Industry				
2 should be filed th and Mental H 27 is marked of traumatic ever		18. Mother's Nam Viola L ailing Address (Street and Number or Run) Folkstone Road, B	al Route Number, City	or Town, State, Zip Code)				
it. Page 1 and 2 rtment of Healt rtant: If item 2 njury or other	20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 20b. Place of Disposition Cemetery, Gate of Disposition	sposition (Name of crematory or other place) Ja Heaven Cemetery	Date 20c. 20c. 20c. 20s. S	Location - City or Town, State				
Physician/	23a. Part 1. Enter the disease, or complications that caus, the death. Do not shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition COMPLICATIONS OI	enter the mode of dying, such as cardiac	d. W., Sil	ome Inc. ver Spring, MD 2090 Approximate Interval Between Onset and Death				
attending physician and for use as the burial-transit or use as the burial	resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):							
at the death certificate I by the attending phy stached for use as the Physician/Medi		3 Ectopic pregnancy 5 Other (specify)		23d. Date of delivery Month Day Year				
The law requires that the descrete has been signed by the capage 2 should be detached.	Part II. Other significant conditions contributing to death but not resulting in the CEREBROVASCULAR ACCIDENT	ne underlying cause given in Part I.	1 🗆 Yes	o use contribute to the cause of death? 2 □ No 3 □ Probably 4 👿 Unknown				
sician: The law certificate has be rector, page 2 s	ESSENTIAL HYPERTENSION 25. Was case referred to medical	26. Place of Death (Chec.	24a. Was an autopsy performed? 1 Yes 2	24b. Were autopsy findings available prior to completion of cause of death? No 1 ☐ Yes 2 ☐ No				
or Attending Physician: The law requires that the death certificate after death. Director: After this certificate has been signed by the attending physin by the funeral director, page 2 should be detached for use as the Certificate: To Be Completed by Physician/Medi	examiner? 1	tient 3 DOA Other: 4 Nursing Ho	ome 5 X Residence 28d. Describe how inju					
spital or Atti tours after d eral Directe filled in by t cal Certi	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify) 29a. Certifier 1 【 Certifying Physician: To the best of my knowledge, dea		City or Town, Sta					
To the Hospital or Attending Physici within 24 hours after death. To the Funeral Director. After this ce Completed filled in by the funeral direct Medical Certificate: To E	(Check only one) 3 Certifying Nurse Practioner: To the best of my knowledge 29b. Signature and title of certifier	vestigation, in my opinion, death occurred a je, death occurred at the time, date and place 29c. License number MD# D0058627	the time, date and place, and due to the cause	ce, and due to the cause(s) and manner state				
State Registrar	30. Name and address of person who completed cause of death (Item 23a) (Typ SONIKA PANDEY, M.D., VAMC, 50 IRVIN 31. Date filed (Month, Day, Year) JAN 2 6 2012 C. Registrar's Signature	G STREET NW, WASHIN	IGTON, DC 20	0422/688				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Manth Physician/ 23 Day 2012 ear James Mitchell Smith 3:20 pv Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 13106 Burleigh Street Upper Marlboro Prince Georges 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral 7. Age (In yrs. last birthday) Hours **Director** 228-32-9328 1 M 2 D F 82 03/14/1929 VA show 10b. County 10c. City, Town or Location ral", or items 23a or 28a-f sho Examiner must be notified at 10d. Inside City Limits Director 1 Z Yes 2 No MD Prince Georges Upper Marlboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 13106 Burleigh Street 20774 United States 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. Armed Forces?
1 ✓ Yes 2 ☐ No If Yes, specify Cuban, Mexican, Puerto Rican, etc. 0. Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give 3 Divorced Specify: Black Completed Year or Dates 951-56 permit. Page 1 and 2 should be filed within 72 hour. Degartment of Health and Mental Hygiene.
Important: If item 27 is marked other than "natur engar, ijury or other traumatic event, the Medical E 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Truck Driver Grocery Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 James David Smith Hazel Novella Thompson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy E. Smith (wife) 13106 Burleigh St. Upper Marlboro, MD 20774 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 02/01/2012 Triangle, VA 4 Donation 5 Other (Specify) Ouantico 21. Signature of Funeral Service Licenses 22. Name and Address of Facility W.H. Bacon Funeral Home Wandac 3447 14th St. NW Washington, DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Cancer of COLON disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Exami that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day Month Pregnant at time of death 1 ☐ Yes 2 ☐ Unknown g | Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Ninknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform To the Hospital or Attending Physician: The 1 Yes 2 🗌 No Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 Yes ဂ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Nesidence 6 Other (Specify) Manner of Death Certificate: 28a. Date of injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at (Month, Day, Year) Hatural Accident 5 Pending within 24 hours after death.

To the Funeral Director: After

Completely filled in by the fun work 1 Yes 2 No Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical Examiner: On the basis of examination and/or Investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Year

29d. Date signed (Month, Day, Year)

52 5015

12N

State Registrar 29b. Signatur

nd title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

7525 Oreenway

29c. License number

D531113

		Print in Black Indelible In							
	1 - State of State of Registrar	Maryland / Department of I	·	ygiene Reg. No. 2012 0389(
Physician/	1. Decedent's Name (First, Middle, Last)	2. Date of D	leath 3. Time of Death						
Medical	MARJORIE A. SHORT 4a. Facility Name (if not institution, give street and numb.)	ar) the City Town o	Month Older Location of Death	22 20/2 1047 M 4c. County of Death					
Examiner	PENINSYLA REGIONAL ME	edical Center.	544156414	4c. County of Death AIUOMICO					
Funeral Director	5. Social Security Number 6. Sex 7	Age (In yrs. last birthday) 80 Yrs. If Under 1 Year Months Days	Hours Min. (Month, E	Day, Year) Country)					
	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Location	NOV 08	<u>-</u>					
Marylan Ba-f sh tiffied a	MARYLAND WICOMICO	FRUITLAND		10d. Inside City Limits 1 X Yes 2 □ No					
tems 23a or 28a-f she er must be notified at Funeral Director	10e. Street and Number 203 N. DIVISION ST.	10f. Zip Code 218 2	26	10g. Citizen of What Country? UNITED STATES					
r items iner m	11. Marital Status 1 X Never Married 2 Married 1 Yes 2	es? If Yes, specify Cuba	lispanic Origin? (Specify Yes or No an, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.					
rs after or l'Examir		1 Ves 2 No	Specify:	Specify: BLACK					
rithin 72 hours a lene. r than "natural" the Medical Ex	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occup (Give kind of work done	during most of working	16b. Kind of Business/Industry					
within giene. er thar , the M	Elementary/Secondary (0-12) College (1-4	or 5+) life. DO NOT use retired) LINE TECHN		POULTRY PLANT					
1 and 2 should be filed within 72 hours after death with the Manyland if Health and Mental Hygiene. The many file marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at To Be Completed by Funeral Director	17. Father's Name (First, Middle, Last) GEORGE SHORT		18. Mother's Name (First, Middle STELLA WASHI)	ne (First, Middle, Maiden Surname) WASHINGTON					
2 shoul th and traum;	19a. Informant's Name/Relationship (Type, Print) DAVID SHORT (SON)		and Number or Rural Route Numb						
of Health of Health of Health of Titlem 27	20a. Method of Disposition	20b. Place of Disposition (Name of	Date	20c. Location - City or Town, State					
Page nent ant: I	1 X Burial 2 ☐ Cremation 3 ☐ Removal from St 4 ☐ Donation 5 ☐ Other (Specify)	tate HARMONY UMC CEM.		MILLSBORO, DE					
permit. Departr Imports any inji	21. Signature of Filmeral Service Licensee	MO 1361 22. Name and Addre	,	19966 DX 125 MILLSBORO, DE					
100	23a. Part 1. Enter the disease, or completions that caushock, or heart failure. List only on cause on each	used the death. Do not enter the mode of dyin							
Physician/ Medical	Immediate Cause (Final disease or condition resulting in death)	Ascud		Onset and Death					
Examiner	Due to (or as a consequence of):								
kecuted n and al-transit Examiner	Sequentially list conditions, If any, leading to immediate cause. Enter Underlying Due to (or as a consequence of):								
	Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or	as a consequence of):							
ate be on the burning the burning the burning edical	d								
ath certificate be attending physici for use as the bu	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outco			23d. Date of delivery					
The law requires that the death certificate be eath as been signed by the attending physicial page 2 should be detached for use as the burn Completed by Physician/Medical		th 2 ☐ Fetal death 3 ☐ Ectopic pregnand that time of death 5 ☐ Other (specify) vn		Month Day Year					
s tha	Part II. Other significant conditions contributing to dea	tobacco use contribute to the cause of death?							
require been si should l			1 L	Yes 2 No 3 Probably 4 Unknown					
The law require cate has been si page 2 should			auto	ppsy prior to completion of cause of death?					
ysician: The is certificate director, pag	25. Was case referred to medical examiner?	Out	ace of Death (Check only one)	2,00,100					
Attending Physician: r death. setor: After this certific by the funeral director, rrificate: To Be (27. Manner of Death 28a. Date of		4 □ Nursing Home 5 □ Res y at 28d. Describe	idence 6 Other (Specify) how injury occurred					
or Attending F after death. Director: After i In by the funer.	1 Natural 5 Pending (Month, Day, Year) injury work? 2 Accident Investigation M 1 Yes 2 No								
al or At after of Direct d in by	4 Homicide determined 28e. Place of building.		28f. Location (Street and Number or Rural Route Number, City or Town, State)						
To the Hospital or Attending Physical or Within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di Medical Certificate: To	29a. Certifier 1 Certifying Physician: To the best (Check 2 Medical Examiner: On the basis	of my knowledge, death occurred at the time	e, date and place, and due to the c	cause(s) and manner as stated. and place, and due to the cause(s) and manner stated					
Forthe Post Vithin 2 Complete Formplet	only one) 3 Certifying Nurse Practitioner: To 29b. Signature and title of certifier	the best of my knowledge, death occurred at t	he time, date and place, and due to	the cause(s) and manner as stated. 29d Date signed (Month, Day, Year)					
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Chils Snygli, D.O. 160 E. Callol St. SALISbully, MD 2180] 31. Date filed (Month, Day, Year) 32. Plegistrar's Signature								
BA 3	30. Name and address of person who completed cause of CNNS SNYQW, D.O.	of death (Item 23a) (Type, Print)	SALISBULLY, MO	2/80/					
State Registrar	31, Date filed (Month, Day, Year) 32. Pegi JAN 2 6 2012 32.	strar's Signature	/						
	-								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year Swontek SR John 01 2012 1:12 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ATLANTIC GENERAL HOSPITAL WORCESTER BERLIN 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth
(Month, Day, Year)
JAN. 9, 1933 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 🌠 M 2 🗆 F MARYLAND 79 219-28-3254 Yrs. Director Usual Residence of Decedent items 23a or 28a-f shov her must be notified at 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 □ No MARYLAND WORCESTER OCEAN CITY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 142 SANDY HILL DRIVE 21842 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian. or other traumatic event, the Medical Examiner Black, White, etc. 5 þ 1 ☐ Yes 2X No If Yes, Give Page 1 and 2 should be filed within 72 hours after or ment of Health and Mental Hygiene. 1 Never Married 2 X Married 1 ☐ Yes 2 XNo Specify: 3 Divorced 4 Divorced WHITE Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) MEAT PACKER MEAT PROCESSING 8 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည **JOHN** SWONTEK DOROTHY COLLINS and l 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 142 SANDY HILL DRIVE, OCEAN CITY, MD 21842 LOUISE R. SWONTEK/WIFE Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1
Department of I
Important: If it
any injury or of 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 6 ☐ Other (Specify) CREMATORY OF DELMARVA 1/20/12 DELMAR, DELAWARE 21. Signature Fundament Fu 22. Name and Address of Facility HASTINGS FUNERAL HOME, SELBYVILLE, DE. 19975 Part 1. Sater the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part 1. Approximate Interval Between Immediate Cause (Final disease or condition Congestive Heart Failure
Due to (or a a consequence of): Onset and Death Physiciani 409-5 Medical resulting in death) Examiner Atrial Fibrillation
Due to (or as a consequence of): uea Caquantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Artey dizease Corany that initiated events resulting in death) Last Physician/Medical Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Month Day 1 L Yes 2 L 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Obstructive Pulmoney Disease 1 les 2 No 3 Probably 4 Unknown Division of Vital Records, Certificate: To Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed this certificate 2 40 Yes 2 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After 1 Natural
2 Accident
3 Suicide 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Hilleyas, M.O. 00063904

Registrar
DHMH 17 Rev 7/2009

State

370

200

Healthway Drive, Belin MD 218/1

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9733

3. Registrar's Signature

Giller

31. Date filed (Month

Day, Year) 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ 23- 30 12 Month William Albert Sargent A M 01-1:19 Medical 4a. Facility Name (if not institution, give street and number, Examiner 4b. City. Town, or Location of Death 4c. County of Death Salisbur Wicomico Coastal Hospice at the Lake . Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** (Month, Day, Year) Director 113-24-4526 1**X** M 2 □ F 08 30 1934 NY Usual Residence of Decede or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 □ No MD Wicomico Salisbury 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be 1 Funeral 21804 1012 E. Schumaker Manor Dr. USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? 1 X Yes 2 ☐ No Black. White, etc. by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 X Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working Elementary/Secondary (0-12) life. DO NOT use retired) College (1-4 or 5+) Job Placement Owner Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Doris Williams Howard Albert Sargent 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Timothy Sargent | Brother 1514 Windham Court, Salisbury, MD, 21804 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Salisbury Crematory 01 23 2012 Salisbury, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Holloway Funeral Home P.A. ▶ 501 Snow Hill Rd., Salisbury, MD, 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate nterval Between Immediate Cause (Final Onset and Death Metastali Physician, Neuro Endo anne disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading cause. Enter Underlying Examiner or Attending Physician: The law requires that the death certificate be executed Cause (Disease or Injury that initiated events and burial-tra resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the, use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 1 Live Birth 2 Fetal deat
4 Pregnant at time of death
9 Unknown 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No ģ Month igned by the at be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 Yes 2 No 3 Probably Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 autopsy perform death? After this certificate Yes P No 1 Yes funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hach မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred U Natural Natural injury 5 Pending work? within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 🗌 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town. State: To the Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

State

(Check

3 🗆

JAN 25

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signat

VOHRA

29b. Signature and title of certifie

OGESH

31. Date filed (Month,

Registrar

910 EASTERN SHORE OR.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

D63199

29d. Date signed (Month, Day, Year)

22/12

SAUSBURY

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2012 25, 2342 Richard Henry Speide1 Jan. Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Bethesda Suburban Hospital Montgomery Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** Hours **Director** 220-32-5632 1 🕱 M 2 🗆 F 91 Jun 18, 1920 Louisville, KY Usual Residence of Decedent show 10a. State death with the Maryland 10c. City, Town or Location 10d, Inside City Limits Director r 28a-f sl notified MD Montgomery Bethesda 1 X Yes 2 No ö 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be Funeral 4814 Westway Drive 20816 IISA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, "natural", or ite Black, White, etc. þ 1 Never Married 2 Married 1 X Yes If Yes, Give 2 No 1943 Baltimore, Maryland 21215-0036 72 hours after 1 Yes 2 No Specify. White Specify: Completed 3 Divorced 4 Divorced 1947 Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Lawyer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) th and Mental F 27 is marked of traumatic ever t. Page 1 and 2 should be fill tment of Health and Mental rtant: If item 27 is marked ၉ Frederick George Speidel, MD Theresa Henry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth C. Speidel - Wife 4814 Westway Dr., Bethesda, MD other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State = 5 1 Burial 2 X Cremation 3 Removal from State Department of Important If any injury or once. Metropolitan Crematory 1/29/12 4 Donation 5 Other (Specify) Alexandria, VA Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Ave. Gasch's Funeral Home, P.A. Hyattsville, MD 20781 Enzy 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardia respiratory arrest. Approximate Interval Between 1 Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Ph_sician/ Intracranial Hemorrhage disease or condition resulting in death) mo ome Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) and that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 2 No 9 Unknown Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, Pulmonary embolism 1 \square Yes 2 \blacksquare No 3 \square Probably 4 \square Unknown Atrial fibrillation 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No Yes 2 X No Physician: of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other 2 1 Nation 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, 1/25/12 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 24 hours after death. Natural 5 Pending Division Certifical XAccident 0100 1 Yes 2X No Fall M Investigation within 24 hours after deat To the Funeral Director: 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4814 Westway Dr. determined building, etc. (Sp. Bethesda, MD 20816 🖾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Dedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 1/26/ MD72288 M)

State

Speidel

Richard

DHMH 17 Rev 06-2011

Registrar

8600 Old Georgetown Rd, Bethesda, MD 20817

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signatu

Leigh Burnstein

JAN 3 0 2012

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

		Flease	Ctete of Ma					_	7.		
		For State	State of Ivia	,	partment of l ertificate of l			001	2 03894		
		Registrar	n#)	Death	neg. No. / / / / O O						
Physicia	n/	Decedent's Name (First, Middle, La. Jane Stalling			2. Date of Deat Month	Day Year	3. Time of Death				
Medic		4a. Facility Name (if not institution, give			Ala City Town o	or Location of Death		4c. County of De	13.00 11		
Examin	er			or	Lonacon		1	Allegan			
Funeral		Egle Nursing and 5. Social Security Number 6. S		(In yrs. last birthda			8. Date of Birth	9. B	Y irthplace (State or Foreign		
Director			□M2 1 65		Months Days	Hours Min.	Jan. Day,	Year) 947 M	aryland		
M		Usual Residence of Decedent									
yland f shc ed at	tor	10a. State 10b. County		10c. City, Town or					10d. Inside City Limits		
Mar 28a notifi)ire	MD Allegan	У	Frostbu					tx Yes 2 ☐ No		
th the	al [10e. Street and Number			10f. Zip Code 21532	1	1	U. S. A.	Country?		
ith wi	Funeral Director	9 B East Mecha	12. Was Decedent Ev				acifu Vac or No				
or ite	by F	11. Marital Status1 ☐ Never Married2 ☐ Married	Armed Forces?	lo	If Yes, specify Cub	s Decedent of Hispanic Origin? (Spec es, specify Cuban, Mexican, Puerto F		14. Race - An Black, Wh			
s afte	Completed b	1 Never Married 2 Married 3 Widowed 4 Oniversed 1 Yes 2 No If Yes, Give			1 🗆 Yes 2 🔼 No	Specify:		Specify:	White		
hour natu dical		15. Decedent's E (Specify only highest gr	Education		cedent's Usual Occup		tring	16b. Kind of Busines	· · · · · · · · · · · · · · · · · · ·		
nin 72 he. han '	mo	Elementary/Seconday (0-12)	College (1-4 or 5+	life	ve kind of work done . DO NOT use retired		K#19	5 3 - 64			
ygier ygier her t	Be C	12	4 +	Te	eacher	T		Educati	on		
e filec ntal H ed ot ever	To B	17. Father's Name (First, Middle, Last) Robert Stallings					ne (First, Middle, M caham) St				
uld b d Mer nark natic						1					
2 sho th and 7 is r traur		19a. Informant's Name/Relationship (1 Richard Delaney	ype, Print) Son		ailing Address (Street 28 Scott S			City or Town, State, 2 VA 22153	Zip Code)		
and Heali tem 2		20a. Method of Disposition	DOM		sposition (Name of	1		20c. Location - City of	or Town State		
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at once.		1 Burial 2 Cremation 3 4 Donation 5 Other (Speci		cemetery, c	rematory or other pla			Frostburg			
artme ortan injur		21. Signature of Funeral Service Licen		Troscou	22. Name and Addre			eral Servi			
permi Depar Impor any ir once.		John J.	In Dow.	Ma		tional Hv			1502		
		23a. Part 1. Enter the disease, or com	plications that caused		enter the mode of dyi	ng, such as cardiac	or respiratory arres	st,	Approximate		
Physician/		23a. Part 1. Enter the disease, or complications that caused find death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Shock, or heart failure fulst only one carge on each line. Immediate Cause (Final disease or condition AMYOTROPHIC LATERAL SCLEROSIS Onset a									
Medical		disease or condition resulting in death)		Due to (or as a consequence of):							
Examiner		Convertibility list and distance	h								
	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a	consequence of):							
cuted nd :ransi	хаш	Cause (Disease or iinjury that initiated events	c								
s be executed /sician and e burial-transit	cal E	resulting in death) Last	Due to (or as a	consequence of):							
ate brothysic the b			d								
aath certificate b attending physi I for use as the b	Physician/Med	IF FEMALE:	23c. If yes, outcome o	f pregnancy							
ath co	cian	23b. Was decedent pregnant in the past 12 months?	1 Live Birth 2	Fetal death		23d. Date of d	d. Date of delivery Month Day Year				
the dec	ysi	1 ∐ Yes 2 t⊭l No 9 □ Unknown	9 Unknown	anto or death	5 ☐ Other (specify) _						
that the	by Pł	Part II. Other significant conditions	ontributing to death bu	t not resulting in th	e underlying cause g	iven in Part I.	23e. Did tob	acco use contribute	to the cause of death?		
n sign	g p∈						1 □ Ye	s 2 No 3 Probably 4 Unknown			
v requ	Completed						24a. Was ar		utopsy findings available		
he lav te has age 2	om						autops perform	ned? death?	completion of cause of		
an: T tifica tor, p	Be C	25. Was case referred to medical			26. F	Place of Death (Chec		Y No 1 ⊔ Y	es 2 🗆 NO		
ysici lis cel direc	To E	examiner? 1 Yes 2 No	Hospital: 1 lnpatier	nt 2 🗆 ER/Outpa	tient 3 DOA Oth	ner: 40 Nursing H	nce 6 Other (Spe	e 6 🗆 Other (Specify)			
ig Ph ter th neral		27. Manner of Death 1 Natural 5 Pending	28a. Date of injury (Month, Day,			ry at	28d. Describe ho				
eath. or: A	ifica	2 Accident Investigatio	n			Yes 2 ☐ No	28f. Location (Street and Number or Rural Route Number, City or Town, State)				
or Ath	Certificate;	4 Homicide determined	28e. Place of Injury building, etc.		street, factory, office						
pital ours a sral C											
Hos 24 ho Fune eted i	Medical	29a. Certifier (Check (
To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completed filled in by the funeral director, page 2 should be detached for use as the	Σ	only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner 29b. Signature and title of certifier 29c. License number 29d. Date signed (Mo)									
C > F O		Hadin				12/67			ERRUARY 03, 2012		
PW		30. Name and address of person who		ath (Item 23a) (Type				しったいたい	(), 2-12		
00		Harjit Sidhu	, 925 Bisho	p Walsh	Rd., Cumbe	erland, M	D 21502				
Stat		31. Date filed (Month, Day, Year) FFB 1 0 2012	32. Registrar	s Signatur	and the						
Registra	17	LED TO COL	ALCOHOL IN								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 201^{Yea} David Berry Stagg 1:55 A. January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 6507 Monarch Road Frederick Frederick Social Security Number If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral Director** 230-54-2957
Usual Residence of Deceden 1 🛛 M 2 🗆 F Connecticut 70 06/16/1941 28a√f shov must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2X No MD Frederick Frederick 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a United States 6507 Monarch Road 21703 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Examiner Armed Forces?
1 X Yes 2 No
If Yes, Give 1 06 Black, White, etc <u>-</u> Completed by 1 Never Married 2 X Married 2 should be filed within 72 hours after thand Mental Hygiene.
27 is marked other than "natural", or traumatic event, the Medical Examir Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: White 3
Widowed 4 Divorced r Yes, Give Year or Dates. 1960-63 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) Independent courier Delivery Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Harold George Stagg June Evelyn Ward 1 and 2 should be of Health and Me item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6507 Monarch Road, Frederick, MD 21703 Margaret E. Stagg/ wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o 1 Kurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mt. Olivet Cemetery | 02/03/2012 | Frederick, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Reeney & Easford Funeral Rome MO1222 106 E. Church St., Frederick, MD 21701 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate bladdo. Interval Between Immediate Cause (Final disease or condition Onset and Death METASTATIC Ph sician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) attending physician and for use as the burial-transit that the death certificate be executed Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy
5 Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month g Unknown P.O. Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ To the Hospital or Attending Physician: The law requires within 24 hours after death.

To the Funeral Director: After this certificate has been sign Division of Vital Records, 1 🗂 Yes Completed 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 🗹 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending I Director: A 1 ☐ Yes 2 ☐ No ☐ Accident☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) 01-30-2012 DO067691

Registrar

DHMH 17 Rev 06-2011

Frederich

MID

21701 / Dr. Mark Goldstein

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2012

501

31. Date filed (Month, Day, Year,

Street

32. Registrar's Signature

			For State	State o	f Marylar		artment of H		ınd M	lental Hyg	iene 20	12	03	896
		-	Registrar 1. Decedent's Name (First, Middle		Certificate of Death				2. Date of Deat		3 Time	of Death		
ь	Physicia		,	John Mic	hael Th	omas						012		52 A M
and to	Medic Examin		4a. Facility Name (if not institution			2011140	4b. City, Town, or	Location of	Death	ounuar)	4c. County		101.	72 21
Samuel State of State			Frederick	Memorial	Hospit	al	F	rederi	ick]	Frede	rick	
ă	Funeral		5. Social Security Number		7. Age (In yrs. i	last birthday)	If Under 1 Year Months Days	If Under 24 Hours	4 Hrs. Min.	8. Date of Birth (Month, Day,	Year)	9. Birthp		e or Foreign
	Director		217-64-7575 Usual Residence of Decedent	1 ■ M 2 □ F	6	Yrs.				Dec.21,			Yorl	ĸ
	and show	5	10a. State 10b. County			ty, Town or Loc	ation			200121	1751			City Limits
	Maryla 8a-f	Director	Maryland Mon	tgomery			Dat	nascus					1 🗆 Y	res 2 No
	the land		10e. Street and Number	-8			10f. Zip Code			1	0g. Citizen of V	Vhat Cour	ntry?	
	n with	Funeral	25721 Vall	ey Park T	errace		20	0872				USA		
	deatl riterr iner n	by	11. Marital Status	Armed For			Vas Decedent of Hi Yes, specify Cuba	spanic Origii n, Mexican, I	in? (Spec Puerto F	cify Yes or No- Rican, etc.)		e - Americ k, White, e		
36	after al", o xami		1 ☐ Never Married 2 Married 3 ☐ Widowed 4 ☐ Divorced	If Yes, Giv	е	1	☐ Yes 2 ♠ No	Specify:			Specify:			
9-0	hours natur ical E	Completed	15. Deceder	nt's Education	ites.	16a, Deced	ent's Usual Occupa	ation			16b, Kind of Bu	eineee/In	Whit	:e
215	in 72 e. na n " ı Med	μď	(Specify only highe Elementary/Secondary (0-12)	st grade completed) College (1-	4 or 5+)	(Give F	rind of work done d O NOT use retired)	luring most o	of workin	ng .	TOD, TAITE OF DE	31103371110	adoti y	
21	withi ygien ygien t, the	To Be Co	, , , , , , , , , , , , , , , , , , , ,	2		Cu	stomer Se	ervice	Rep	o	E	lectr	ical	
and	e filec ntal H ed otl		17. Father's Name (First, Middle, L	,						(First, Middle, M		•		
Ŋŝ	d Mer d Mer mark matic		John Richard						-	et Pasch				
Ma	2 sho th an 27 is trau		19a. Informant's Name/Relationsh		774 £ -		g Address (Street a							
ē,	f Heal		Patricia Diane 20a. Method of Disposition	Inomas,	20b. F	Place of Dispos	721 Valle				mascus . 20c. Location -			<u>′</u>
mo	bage eent o		1 Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		Ciale		e Cemeter	· .		7,2012 M		•	-	1
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Lumeral Service L	A	1 11.									1
<u>m</u>			// Janual	Oynala	150	M 2	6401 Ridg	n-Will ge Roa	id, I	s, P.A., Damascus	MD 20	14 Ho 1872	me	1
21. Signature of fundal Service Livensee 22. Name and Address of Facility Molesworth—Williams, P.A., Funeral 26401 Ridge Road, Damascus, MD 2087 23a. Pat 1. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line.									Approxim Interval B					
, and it	Ph_sician/		Immediate Cause (Final disease or condition		e Renal								Onset and	
Medical Examiner			resulting in death)	Due to (or as a consequ	uence of):								
		er	Sequentially flat conditions if any, leading to immediate	Colon Cancer										
	hed nsit	Examiner	cause. Enter Underlying Cause (Disease or injury											
	execuinand in and ial-tra	Exa	that initiated events resulting in death) Last	C. Due to (Due to (or as a consequence of):									
Ö	cate be executed physician and s the burial-transit	edical												
Box 68760	tificat ng ph		IF FEMALE:											
9 X	eath certific attending p for use as	ian/	23b. Was decedent pregnant in the past 12 months?		Birth 2 🗌 Feta	al death 3	Ectopic pregnancy	y				e of delive	-	
Bo	the at	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregr 9 ☐ Unkn	nant at time of o own	death 5 ∟	Other (specify)				Mor	ith	Day	Year
P.0.	es that the dea signed by the a be detached i		Part II. Other significant condition	ns contributing to de	eath but not res	ulting in the ur	nderlying cause give	en in Part I.		23e. Did toba	acco use contri	bute to th	e cause of	death?
S, F	lires the sign of signs and signs of the sign of the sign	d by									s 2 No			
ord	v requ	lete								24a. Was an	24b. W	Vere autor	sy findings	available
Sec Sec	The law ate has page 2 :	Completed					<u> </u>			autopsy	p d	rior to con eath?	npletion of	cause of
a	ian: T	BeC	25. Was case referred to medical				26. Pla	ce of Death	(Check o	1 \sum Yes 2	No. 1	☐ Yes	2 L. No	
Ξ	hysic his ce il direc	10 E	examiner? 1 Yes 2 No	Hospital:	npatient 2 🗆	ER/Outpatient	3 DOA Other	r: 4 🗆 Nurs	sing Horr	ne 5 🗆 Resider	nce 6 🗌 Other	(Specify)		
JO (ing P	ate:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date o	of injury h, <i>Day, Year)</i>	28b. Time of injury	28c. Injury work?		28	3d. Describe hov	v injury occurre	d		
ior	ttend death stor: A	Certificate:	2 Accident Investig 3 Suicide 6 Could	ation				Yes 2 N						
Division of Vital Records,	after Direc	Cer	4 Homicide determined 28e. Place of Injury - At home, building, etc. (Specify)			me, farm, stre	et, factory, office		28		ion (Street and Number or Rural Route Number, r Town, State)			
Ω	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as	ical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								77			
	ne Ho in 24 I ne Fu pletel	Medical	(Check 2 \(\sum \) Medical E:	kaminer: On the basi Nurse Practitioner:	s of examination	and/or investi	gation, in my opinior	n, death occu	urred at ti	ne time, date and	place, and due	to the caus	se(s) and m	anner stated.
	To the community of the	-	29b. Signature and title of certifier				29c. License number				29d. Date signed (Month, Day, Year)			
			Want WA	DHWA			D00	63498			Janu	ary	22, 2	.012
	5		30. Name and address of person v											
		0	Dr. Lakhvinder 31. Date filed (Month, Day, Year)		400 Wes		Street, F	reder	ick,	MD 217	01			
	Stat Registra		JAN 26	2012	www.	B. 1	arked							

Please Type or Print in Black Indelible Ink, Fnsure All Copies Are Legible. Amend 8 per med cert 6925 3 1112 dk. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Hannah Joy Taulton 2012 Medical January 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 1819 Arnold Road Jefferson Frederick 1996 8. Date of Birth 1 (Month, Day, Year Social Security Numbe If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 M 2 XF Min 220-47-8194 Yrs Director Maryland Usual Residence of Decedent 28a-f shov 10a. State 10b. County ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Frederick Jefferson Maryland 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1819 Arnold Road 21755 USA 11. Marital Status Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 X Never Married 2 Married þ 1 ☐ Yes 2 🌠 No If Yes, Give 3altimore, Maryland 21215-0036 1 ☐ Yes 2 👿 No Specify "natural", Specify Completed 3 Widowed 4 Divorced Year or Dates White the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) 2 should be filed within 72. In and Mental Hygiene.

7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) N/A N/ABe 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Robert Taulton Anita Blough other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Robert Taulton / Father 1819 Arnold Rd., Jefferson, MD 21755 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1/27/2012 Heights Brunswick, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Home 1100 N. Maple Ave., Brunswick, MD 21716 23a. Part 1. Enter the disease, of shock or heart failure. List complications that cause only one cause on each inhe death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final santili Physician/ years disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) death certificate be executed and resulting in death) Last Due to (or as a consequence of) physician a the burial-Physician/Medical attending ph IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Month Year Day been signed by the should be detached 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Epilepsy Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 performed? Yes 2 No 1 Yes Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 🗷 No Other: 1 🗌 Yes မြ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) Division of 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending within 24 hours at er death.

To the Funeral Director: At completed filled it by the fu 2 Accident
3 Suicide
4 Homicide 1 Tes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title 29c License number 29d. Date signed (Month, Day, Year) 056211 1/22/12 mour 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore, MO 21225 ሳ 3001 S. Henover St. John IrwiN, MP Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Ph sician/ Medical Examiner Physician/ Medical Examiner Approximate Interval Between Onset and Death Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):				For State	State of Ma	d Mental Hy	•	0.0	12	03898			
Examiner Finance For individuo government and normals For finance For individuo government and normals Prince Georges Respital Georges Respital Cheverly For Georges Respital Cheverly For Georges Respital Cheverly For Georges Respital Cheverly For Georges Respital Cheverly For Georges Respital Cheverly For Georges Respital Cheverly For Georges Respital Cheverly For Georges Respital Cheverly For Georges Respital Cheverly For Georges Respital Cheverly The Georges Respital The G	ı	Physicis	n/	1. Decedent's Name (First, Middle, Last	,					eath		Year	3. Time of Death
Princetor Director Di		Medic	cal			Torrence	4h City Toyun or	Lagation of D	Januar	y 26	20	12	0522 ^M
219-38-7529 Windows Services	أمويت		ier						eatti	4			
15 15		Director		219–38–7529					8. Date of Bi (Month, D	rth a <i>y, Year)</i> 1942	2	Count	ry)
Physician Medical Examinor Physician Medical Examinor Examinor Figure 1. Either the disease, or complications that cause the death. Do not effect he mode of dying, such as cardiac or respiratory anest, single-part of death of the cause of part in control of the cause of the		yland f show ed at	ctor	10a. State 10b. County				lhoro			•	10	
Physician Medical Examiner Physician Medical Examiner Sequentially is condition and the cause of complication at the cause of the cause of condition and the cause of the ca		the Mar or 28a- e notifi	Dire					IDOLO		10g. C	Citizen of \	What Count	
Physician Medical Examinor Physician Medical Examinor Examinor Figure 1. Either the disease, or complications that cause the death. Do not effect he mode of dying, such as cardiac or respiratory anest, single-part of death of the cause of part in control of the cause of the		ns 23a must b	neral									USA	,
Physician Medical Examiner Physician Medical Examiner Sequentially is condition and the cause of complication at the cause of the cause of condition and the cause of the ca	036	s after deat al", or iter Examiner	by	1 ☐ Never Married 2 🄀 Married	Armed Forces? 1 ☐ Yes 2 🌠 N If Yes, Give	lf	Yes, specify Cuba	n, Mexican, Pu	' (Specify Yes or No uerto Rican, etc.)	-	Blac	k, White, e	etc.
Physician Medical Examiner Physician Medical Examiner Sequentially is condition and the cause of complication at the cause of the cause of condition and the cause of the ca	2-0	2 hours "natur edical	plete		lucation	(Give k	ind of work done d		working	16b.	Kind of B	usiness/Inc	iustry
Physician Medical Examine Physician Medical Examine Physician Medical Examine Examine Physician Medical Examine Exa	2121	within 7 giene.		Elementary/Secondary (0-12)	,	-)	,	t		Lit	man	Law F	irm
Physician Medical Examine Physician Medical Examine Physician Medical Examine Examine Physician Medical Examine Exa	and	e filed natal Hyge ed other event,	To Be	, , , ,	Torrongo			18. Mother's			_		
Physician Medical Examine Physician Medical Examine Physician Medical Examine Examine Physician Medical Examine Exa	aryl	nould b ind Mei s mark umatic	ľ			19b. Mailin	g Address (Street a						ode)
Physician Medical Examiner Physician Medical Examiner Sequentially is condition and the cause of complication at the cause of the cause of condition and the cause of the ca	Z 6	and 2 sl lealth a em 27 is			ce/Wife	10904	Sutton 1		er Marlb	oro,	MD	20774	
Physician Medical Examiner Physician Medical Examiner Sequentially is condition and the cause of complication at the cause of the cause of condition and the cause of the ca	more	age 1 arent of H		1 🗆 Burial 2 😾 Cremation 3 🗀		cernetery, crem	atory or other place			1		•	
Physician/ Modical Examiner Physician/ Modical Examiner Physi	Balti	permit. F Departm Importa any inju		21. gnature of uneral Service License		22.	Name and Addres	s of Faciliti	onald Tay	lor	II F	Н	
Modifical Examiner Sequentially list conditions				23a. Part 1. Enter the disease, or comp shock, or heart failure. List only on	lications that caused be cause on puch line.						arin		Approximate Interval Between
Sequentially lat conditions, which is all the conditions of the co	-			disease or condition	a. Dun to (or on o	astate	Cancel	10					Onset and Death
Part Language La				Saguantially list conditions	bue to (or as a	consequence on:						-12	
The post of the po		ed sit	mine	day, Isaamy to immediate cause. Enter Underlying	Due to (or se a	consequence of:						- 3	
FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3 Ectopic pregnancy 1 Live Birth 2 Fetal death 3 Ectopic pregnancy 1 Live Birth 2 Fetal death 3 Ectopic pregnancy 1 Live Birth 2 Fetal death 3 Ectopic pregnancy 1 Live Birth 2 Fetal death 3 Ectopic pregnancy 3 Date of delivery 3		execut an and irial-trai	l Exa	that initiated events	c. Due to (or as a	consequence of):						-	
FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3 Ectopic pregnancy 1 Live Birth 2 Fetal death 3 Ectopic pregnancy 1 Live Birth 2 Fetal death 3 Ectopic pregnancy 1 Live Birth 2 Fetal death 3 Ectopic pregnancy 1 Live Birth 2 Fetal death 3 Ectopic pregnancy 3 Date of delivery 3	09	ate be physicia the bu	edica		d							-	
2 5 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State 31. Date filed (Month, Day, Year) 32. Registrar's Signature —	Box 687	e death certific the attending thed for use as	ysician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	1 ☐ Live Birth 2 4 ☐ Pregnant at	! 🗌 Fetal death 3 🔲		<i>y</i>					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State 31. Date filed (Month, Day, Year) 32. Registrag's Signature	ls, P.O.	uires that the n signed by uld be detac	by	Part II. Other significant conditions co	ntributing to death bu	t not resulting in the ur	nderlying cause giv	en in Part I.					
2 5 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State 31. Date filed (Month, Day, Year) 32. Registrar's Signature —	Record	The law req ate has bee page 2 sho	Somplet						auto perf	psy ormed?		orior to con death?	npletion of cause of
2 5 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State 31. Date filed (Month, Day, Year) 32. Registrar's Signature —	ta	ician: certifica	Be	examiner?	Hospital:		Othe						
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State 31. Date filed (Month, Day, Year) 132. Registrar's Signature	ot <	ig Physicer this		27. Manner of Death	28a. Date of injury	28b. Time of	28c. Injury	4 □ Nursin					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State 31. Date filed (Month, Day, Year) 132. Registrar's Signature	ion	ttendir death. :tor: Afi / the fu	tifica	✓ ☐ AccidentInvestigation			M 1 □			(a			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State 31. Date filed (Month, Day, Year) 132. Registrar's Signature	N N	al or A safter al Direct		4 Homicide determined			et, factory, office					er or Hurai i	route Number,
2 5 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State 31. Date filed (Month, Day, Year) 32. Registrar's Signature —	_	he Hospit in 24 hour ne Funera pletely fill.	Medica	(Check 2 Medical Examir	ner: On the basis of exa	amination and/or investi	gation, in my opinio	n, death occurr	red at the time, date	and plac	e, and due	e to the cau	se(s) and manner stated.
State 31. Date filed (Month, Day, Year) 32. Registrati's Signature		To the common common		29b. Signature and title of certifier			29c. License	number SZZZ		29d. D	ate signed	(Month, E	'ay, Year)
	2	5			ompleted cause of de	ath (Item 23a) (Type, Pr	int)	cny	Su.4	210	Pr	V- 0.	II) MP ZIG
T TO T T T T T T T T T T T T T T T T T					32. Registrar	's Signature						•	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		State of Maryland /				and N	/lental Hy	giene	0010	00000
		1 - State Registrar	Cei	tificate of L	Death			Reg. No	2012	03899
Physicia	an/	1. Decedent's Name (First, Middle, Last) RONALD O. WINTERS					Date of De Month	Day	y Year	3. Time of Death
Medi		4a. Facility Name (if not institution, give street and number)		Ab City Tourn or	Location	of Dooth	01/	23/2		1:00 P ^M
Examir	ier	1396 STONE CREEK RD		4b. City, Town, or ANNAPOL		or Death			County of Death	
Funeral	г	5. Social Security Number 6. Sex 7. Age (In yrs. last bird	thday)	If Under 1 Year	If Under		8. Date of Bir	th		place (State or Foreign
Director		577-46-4122 1 XM 2 □ F 76	Yrs.	Months Days	Hours	Min.	05/12/47	1935		INGTON DC
nd how at	5	Usual Residence of Decedent 10a. State 10b. County 10c. City, Tow	n or Lo	cation					WASI	10d. Inside City Limits
//anyla Ba-f s tified	Director	MD ANNE ARUNDEL ANNAPO	LIS							1 Yes 2 XNo
the Na or 2		10e. Street and Number		10f. Zip Code					izen of What Cou	intry?
Iryland 21215-0036 build be filed within 72 hours after death with the Maryland of Mental Hygiene. marked other than "natural", or items 23a or 28a-f show matic event, the Medical Examiner must be notified at	Funeral	1396 STONE CREEK RD		21403				USA		
r iten iner r		11. Marital Status 1 □ Never Married 2 ☒ Married 12. Was Decedent Ever in U.S. Armed Forces2 1 □ Yes 2 ☒ No	13. \	Vas Decedent of Hi f Yes, specify Cuba	spanic Ori n, Mexicai	igin? (Spe n, Puerto	cify Yes or No- Rican, etc.)		14. Race - Ameri Black, White,	
o36 s after al", o Exam	d by	1 ☐ Never Married 2 🛣 Married 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates.	1	☐ Yes 2 🔀 No	Specify.				Specify:WHIT	
5-0 hour	Completed	15. Decedent's Education 16a		lent's Usual Occupa				16b. Ki	nd of Business/Ir	ndustry
hin 72 he. than "	шо	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)		kind of work done a O NOT use retired)	lunng mos	t of worki	ng			
d with	Be C	12 Po	OLI	CE OFFICE					ENFORCE	MENT
Maryland 21215-0036 2 should be filed within 72 hours after th and Mental Hyglene. 27 is marked other than "natural", o traumatic event, the Medical Exam	To E	DOUGLAS W. WINTERS JR.					e (First, Middle, 1. NICH(· ·	
Taryland 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f sho aumatic event, the Medical Examiner must be notified at			Mailin	g Address (Street a						Codel
≥ ≥ ≦ 5 ±	10	ROSEMARY WINTERS-WIFE 1	396	STONE CR	EEK I	RD AN	NAPOLIS	S MD	21401	Code,
O - O - L	1			sition (Name of natory or other place	e)		Date	20c. Lo	cation - City or T	own, State
Limor Page 1 Iment of tant: If it jury or o		4 Donation 5 Other (Specify)	ÉAKI	E CREMATI	ON	01/2	7/2012	STEV	VENSVILL	E MD
Baltimo		21. Signature of Funeral Service Licensee	22 HI	. Name and Addres	s of Facilit	LAST	TNG TR	RHTE	ES BY FE	T.T.OWS -
		23a Part 1. Enter the disease, or complications that caused the death. Do n		ELFENBEIN A. 814 B					olis, MD	
Physician/		shock, or heart failure. List only one caus— each line.			9, 30011 83	cardiac o	respiratory ari	C31,		Approximate Interval Between Onset and Death
hysician/ Medical		disease or condition resulting in death) a. Due to (or as a consequence of the control of the c		uncel					-	
Examiner			,-							
±	Examiner	Sequentially list conditions, lif any, leading to immediate cause. Enter Underlying	of):							
executed an and rial-transi	xan	Cause (Disease or injury that initiated events c.	_							
S Ci. e	dical E	resulting in death) Last Due to (or as a consequence of	OT):							
/6U	edic	d								
os/ certifica nding p	N/M	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy							23d. Date of deliv	en/
box death death he atter	Physician/Me	in the past 12 months? 1 Live Birth 2 Fetal death 1 Yes 2 No 4 Pregnant at time of death		Cther (specify)	У				Month	Day Year
by the	Phys	g Unknown								
s that the igned by	व	Part II. Other significant conditions contributing to death but not resulting i	n the ui	nderlying cause give	en in Part	l.				he cause of death?
rdS equire een s hould	eted						1 🗆 `	res 2 L	」No 3 ☐ Pro	bably 4 Aunknown
VItal KECOrds, ysician: The law requires is certificate has been sig director, page 2 should be	Completed						24a. Was a autop	sy	prior to co	psy findings available impletion of cause of
The The ficate or, pag		25. Was case referred to medical					1 Tes	med? 2 No	death?	2 🗆 No
AICa sicial certi	To Be	examiner?		Otho	r:					
OT V g Phy er this		27. Manner of Death 28a. Date of injury 28b. T	ime of	28c. Injury	at		me 5 💋 Resid 8d. Describe h		Other (Specify occurred)
on endin eath. or: Aft	ficat	2 Accident Investigation	njury	M 1 🗆 Y	? Yes 2 🗌	No				
IVISION OT or Attending Pl after death. Director: After tt in by the funera	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, far building, etc. (Specify)	rm, stre	et, factory, office		2	28f. Location (S City or Tow		Number or Rura	Route Number,
pital o	Salc									
e Hos 24 hc Fune letely	Medical	29a. Certifier Certifying Physician: To the best of my knowledge, of (Check A Medical Examiner: On the basis of examination and/or	r investi	gation, in my opinior	n, death oc	curred at	the time, date ar	nd place,	and due to the ca	use(s) and manner stated.
DIVISION OF VITAL RECORDS, P.O. BOX 68/61. To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. The Funeral Director. After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the	2	only one) 3 Certifering Nurse Practitioner: To the best of my knov 29b. Signature and live of certifier	vieuge,	29c. License		e and plac			s) and manner as signed (Month,	
		▶ Mo		06	SZAZ	2			4110	
II AT		30. Name and address of person who completed cause of death (Item 23a) (I		rint)					Δ	
At OU.		JASUA LINGY ZUDB MID	LC.	SILVY	JV1.	te ?	210 1	100	· Poly M	10 21401
Stat Registra	- I	31. Date filed (Month, Day, Year) JAN 2 6 2012 32. Registrar's Signature	1	a de d					•	
Hogistic		g.	11/1	W.Co.						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		•	1 - State of State of Registrar		artment of Healtr rtificate of Death		giene _{Reg. No.} 2017	2 03900					
	Physicia Medic		1. Decedent's Name (First, Middle, Last) Mildred P. Witherspoon			2. Date of De Month	Day Year	3. Time of Death 9:05 A. M					
	Examir		4a. Facility Name (if not institution, give street and number Washington Adventist Hosp	•	4b. City, Town, or Location Takoma Park	n of Death	4c. County of Dea	th					
	Funeral Director			Age (In yrs. last birthday) 90 Yrs.	1	er 24 Hrs. 8. Date of Birt	h 9. Bir	thplace (State or Foreign ountry)					
	f show	tor	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo		T URAY T		10d. Inside City Limits					
	he Man or 28a-	Director	MD Montgomery 10e. Street and Number	Silver S	pring 10f. Zip Code		10g. Citizen of What Co	1 ¥ Yes 2 □ No					
	th with t ms 23a must be	Funeral	1000 Daleview Drive		20901		United Sta	-					
9800	1 and 2 should be filed within 72 hours after death with the Maryland f Heath and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	ڇ	11. Marital Status 1 □ Never Married 2 □ Married 1 □ Yes 2 1 ☐ Yes, 2 If Yes, Give Year or Dates	Was Decedent of Hispanic C If Yes, specify Cuban, Mexica 1 ☐ Yes 2 🙀 No Specif		14. Race - Ame Black, Whit Specify: Bl a	e, etc.						
21215-0036	thin 72 horne. than "nat	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4)	or 5+) (Give	dent's Usual Occupation kind of work done during mo O NOT use retired)		16b. Kind of Business						
2 2	be filed wil lental Hygie rked other ic event, th	Be	17. Father's Name (First, Middle, Last)	Care	teria Supervi 18. Mot	ther's Name (First, Middle,	Public Scho	OOIS					
Maryland	should be file n and Mental I 7 is marked o raumatic eve	10	Hamilton Ward 19a. Informant's Name/Relationship (Type, Print)	49, 14, 11		ita Davis							
	and 2 sho Health an tem 27 is ther trau		Marcia A. Johnson/Daughter	1.0	ng Address (Street and Numi Averasboro Dr			o Code)					
Baltimore,	permit. Page 1 a Department of H Important: If itel any injury or oth		20a. Method of Disposition 1										
Bal	permit Depar Impor any in		21 nature of Funeral Service Licensee	/2000000	2. Name and Address of Faci 013 Annapolis	™Columbia Mc		vices,P.A.					
4	- Trysician/		23a. Part 1. Enter the disease, or complications that cau shock, or heart failure. List only one cause on each Immediate Cause (Final	sed the death. Do not enter	er the mode of dying, such a	est,	Approximate Interval Between Onset and Death						
	Medical Examiner		disease or condition resulting in death) a a Due to (or	as a consequence of):	enia.								
	P ₩0	Examiner	cause. Enter Underlying	as a consequence of):	bry f	- Line							
	certificate be executed nding physician and use as the burlal-transit	il Exar	Cause (Disease or iinjury that initiated events c. Due to (or resulting in death) Last	as a consequence of):	rosq 5	al in C							
09/	icate be g physic is the bu	fedical	d										
X P P	death cert ne attendin ed for use	Physician/N		th 2 ☐ Fetal death 3 ☐ nt at time of death 5 ☐	Ectopic pregnancy Other (specify)		23d. Date of de Month	livery Day Year					
7. Ö.	s that th gned by se detac	by Ph	Part II. Other significant conditions contributing to deat	h but not resulting in the u	inderlying cause given in Par	200. 210 10	bacco use contribute to						
ords,	require been si should b	leted			· -	1 🗆 1		robably 4 Unknown					
Vital Records,	The law cate has page 2	Completed				autop	sy prior to or med? death?	completion of cause of					
Ита	s certific	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No Hospital:	eatient 2 - ER/Outpatien	Other:	eath (Check only one) Nursing Home 5 Resid	C \(\tau \)	:£ 1					
on or	To the Hospital or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director, After this certificate has been signed by it completed filled in by the funeral director, page 2 should be detach.	Certificate: T	27. Manner leath 1 leatural 5 Pending 2 Accident Investigation	ow injury occurred	rry)								
DIVISION OF	al or Atte s after de al Directo ed in by th			Injury - At home, farm, streetc. (Specify)	eet, factory, office	28f. Location (S City or Town	treet and Number or Rui n, State)	ral Route Number,					
_	he Hospit in 24 hour he Funera	Medical	29a. Certifier (Check (Check only one) 3 ☐ Certifying Physician: To the best 2 ☐ Medical Examiner: On the basis of the configuration o	of examination and/or invest	tigation, in my opinion, death o	occurred at the time, date ar	d place, and due to the	cause(s) and manner stated.					
	of with the second of the seco		29b. Signature and title of certifier		29c. License number		29d. Date signed (Month	12					
	-14-5		30. Name and address of person who completed cause o	of death (Item 23a) (Type, P	Print) TAG	minh 12 2	.903 Hm	アク					
	Stat Registra		31. Date filed (Month, Day, Year) JAN 19 2012 32. Regis	strar's Signature	Red.								

	Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene													
		For State	State of	Marylan					and N	lental Hy		00	10	00001
-		Registrar 1. Decedent's Name (First, Middle	e. Last)		Cei	tificate	OT L	<i>Death</i>		2. Date of De	Reg. N	lo. /	16	3. Time of Death
Physicia Medic		, , , , =	Lorraine E	Ellen V	vendel					Month Janu		17.	2 ^{Year} 2012	2015 M
Examin		4a. Facility Name (if not institution	. •	,	0	4b. City,	Town, or	Location o				c. County	of Death	
Funeral		Montgomery 5. Social Security Number		Sputal Age (In yrs. I		If Under	1 Year	Olne If Under 2	-	8. Date of Bi	rth			tgomery olace (State or Foreign
Director		089-30-6871	1 □ M 2 X F	73		Months	Days	Hours	Min.	(Month, Da 01/03	ay, Year)	39	Coun	
ind show at	'n	Usual Residence of Decedent 10a. State 10b. County		10c. Cit	ty, Town or Lo	cation				1	10d. Inside City Limits			
Maryla 28a-f s	Director	Maryland Ho	oward					Jessu	.p				- 1	1 Yes 2 No
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ral D	10e. Street and Number	(I) = 1 = 4 (I) = 4			10f. Zip	Code	0.07	0.4		10g. C	Citizen of V		
ems 2	Funeral	11. Marital Status	Wades Way	ent Ever in U.S	S. 13. \	Vas Decede	ent of His	207		cify Yes or No-		14 Page		.S.A.
fter de ', or it amine	by	1 Never Married 2 🗶 Mar	ried Armed Force	es?		f Yes, speci			Puerto	cify Yes or No- Rican, etc.)		Blac	k, White,	etc.
ours a atural'	eted	3 Widowed 4 Divorced	Year or Date	s.								Specify:		White
n 72 h e. ian "na Media	Specify: Specify:											ısiness Ind	dustry	
d withi ygiene her th nt, the	Be Co	12		01 0+)		Acc	coun	tant				Ow	n Bu	siness
oe filec antal H ced ot c ever	To B	17. Father's Name (First, Middle, L Unknown	.ast)					18. Mothe		e (First, Middle, Doroth)	
hould I s marl umati		19a. Informant's Name/Relationsh	nip (Type, Print)		19b. Mailir	ng Address	(Street a	and Number	-	Route Number			tate. Zip C	
nd 2 sl ealth a m 27 i		Nancy Wendel .	- Daughter							ıp, Mar		-		
ge 1 a tr of H :: If ite		20a. Method of Disposition 1 🔀 Burial 2 🗌 Cremation	3 Removal from Si	tate c	Place of Dispo cemetery, cren	natory or ot	her place			Date		Location -	-	
nit. Pa artmei ortant injury		4 ☐ Donation 5 ☐ Other (S		Gat	e of H					3/2012				
21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Service Licensee 23. Name and Address of Facility Hines-Rinaldi Funeral Service Licensee														
		23a. Part 1. Enter the disease, or shock, or heart failure. List of	complications that cau	used the deat line.	h. Do not ente	er the mode	of dying	g, such as c	cardiac o	r respiratory a	rrest,			Approximate Interval Between
Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)		as a consequ	N PA	veuv	NON	itiv	S				_	Onset and Death 2 weeks
Examiner		Securation list can dition			- 4 + C	er								Smouths
D ## A	Examiner	b. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events that initiated events												
e executed cian and purial-transit	Exar	that initiated events resulting in death) Last		as a consequ		COM	/C 1	PUIN	Mon	ary [)12	ense		
te be e nysicia he buri	dical													
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the br	by Physician/Medic	IF FEMALE:	23c. If yes, outco	me of pregna	incv									
leath c e atten d for u	iciar	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	1 Live Bir 4 Pregna	th 2 ☐ Feta ntattime of o	aldeath 3	Ectopic pa Other (spe		у			ĺ	23d. Date Mor	e of delive nth	ery Day Year
it the d	Phys	9 🗌 Unknown	9 Ll Unknow		things in the second			/ D		-				
res tha signed	d by	Part II. Other significant condition Perinkeral			-		iuse give	en in Pari i.						ne cause of death?
v requi	lete						_			24a. Was	•			osy findings available
The lay ate has	Completed									auto perfo	ormed?	d	rior to coi leath? Yes	mpletion of cause of
ician; certific ector,	Be	25. Was case referred to medical examiner?	Hospital:				_	ce of Death	h (Check					
Physical direction	요 .	1 Yes 2 No 27. Manner of Death	1 🗷 In		ER/Outpatien		Other c. Injury	4 □ Nur		me 5 Resi)
ath. r: After	icate	1 Matural 5 ☐ Pendin 2 ☐ Accident ☐ Investig	g (Month,	Day, Year)	injury	м	work?		- 1	esa. Describe r	now inju	ry occurre	a	
or Atte fter de irecto n by th	Certificate:	3 ☐ Suicide 6 ☐ Could i 4 ☐ Homicide determ	ined 28e. Place of	Injury - At ho , etc. (Specify,	me, farm, stre	et, factory,	office		1	28f. Location (S City or Tov			r or Rural	Route Number,
spital o		29a, Certifier 1 ★ Certifying	Physician: To the bes	t of my knowl	ledge death o	occured at t	ne time	date and a	lace and				r oc ctato	d
he Hos in 24 h he Fun pleted	Medical	(Check 2 L Medical E	xaminer: On the basis Nurse Practioner: To	of examinatior	n and/or invest	igation, in m	y opinior	n, death occ	curred at	the time, date a	and place	e, and due	to the cau	use(s) and manner stated.
\$ 1 kg 5 6 5		29b. Signature and title of certifier	I P. 11					number				ate signed		
		30. Name and address of person v	H Beill				94	190				Janua	ry 1	8, 2012
		Joseph Garrett	Reilly. M.	.D., 3	418 Old	andwo	od C	owrt,	Sui	te 111	, 01	lney,	Mar	yland 20832
Stat Registra		31. Date filed (Month, Day, Year) JAN 19	2012 32. (eg)	istrar's.Signat	8. bo	wed								

		Pleas	e Type or Pri					_		_	
	For State Registrar		State of M	aryland	•	ment of licate of		nd Mental	Hygier _{Reg.}	-2012	03902
Physician/ Medical	1. Decedent's Nam Dorothy		Weir						ary 1		3. Time of Death 1:09 pM
Examiner			ve street and number) ns at Rider	wood V			r Location of D .1ver Si			4c. County of Death P.G.	1
Funeral Director	5. Social Security N 188-16-	4778	Sex 1 □ M 2 🔀 F	e (In yrs. last 88		f Under 1 Year onths Days	If Under 24 Hours	Min. 8. Date of (Montile Sept.	f Birth a, Day Yea	9. Birti 1923	hplace (State or Foreign Intry)
show d at	Usual Residence of 10a. State	f Decedent 10b. County		10c. City, T	own or Locati	on					10d. Inside City Limits
e Mary r 28a-f notifie	MD 10e. Street and Nur		tgomery			r Sprin	ıg		1 40.	0	1 Yes 2 No
teath with the Maryland tems 23a or 28a-f she er must be notified at Funeral Director			lley Lane			20904			10g.	Citizen of What Cor USA	untry?
ter o	11. Marital Status	ried 2 Married	12. Was Decedent Armed Forces?			Decedent of I es, specify Cub Yes 2 1 No		? (Specify Yes or Puerto Rican, etc.	No-	14. Race - Amer Black, White Whi	, etc.
ithin 72 hours allene. r than "natural" the Medical Exc	(Spe	15. Decedent's ecify only highest	Education	1	(Give kind	t's Usual Occu d of work done	during most of	f working	16b	. Kind of Business I	ndustry
within giene. er thar , the M	Elementary/Sec	conday (0-12)	College (1-4 or s	5+)	Homem	OT use retired aker)			Own Home	
Id be filed w Mental Hyg arked othe attic event,	17. Father's Name Charles		•					s Name (First, Mic a Hardma		en Surname)	
12 shou alth and 27 is m ir traum	19a. Informant's Nancy K.		(Type, Print) i/Daughter							or Town, State, Zip Spring,	
Page 1 and tent of Her nt: If item ry or othe	20a. Method of Dis 1 Burial 2 4 Denation	•	☐ Removal from State	cem		on (Name of ory or other pla n Crema		Jan. 21, 2012		. Location - City or T	
permit. F Departm Importa any inju	21. Signature of tu		И	ļie tro	Fra	ame and Addre	essectivity.	ns Funer	al Ho	ome Inc.	g, MD 20901
	shock, or hea	art failure. List only	mplications that caused one cause on each line							ver sprin	Approximate Interval Between
Physician/ Medical	Immediate Cause disease or condition resulting in death)		a. Cerebra. Due to (or as			ccident					Onset and Death 1 week
Examiner 5	Sequentially list co		b. Hyperter		ce of):						unknown
be executed sician and burial-legistrial burial-legistrial burial-legistrial burial-legistrial burial-legistrial burial-legistrial burial-legistrial burial-legistrial burial-legistrial burial-legist	cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last C. Due to (or as a consequence of):										
physician the buria			d								
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the but the funeral director. Be Completed by Physician/Medical Medical Certificate: To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent in the past 12 1 ☐ Yes 2 1 9 ☐ Unknown	months?	23c. If yes, outcome 1 Live Birth 4 Pregnant a 9 Unknown	2 Fetal d	eath 3 🗌 E	ctopic pregnar ther <i>(sp</i> ec <i>ify)</i> _	су	,		23d. Date of deli Month	ivery Day Year
ires that the signed by the detailed be detailed by the bed by the signe			contributing to death t			, , ,	iven in Part I.	1			the cause of death?
The law requate has been page 2 shou			•					_ _	Was an autopsy performed	prior to death?	opsy findings available completion of cause of
sician: certific rector,	25. Was case referrexaminer?	red to medical	Hospital:			Ott	er.	(Check only one)			
th. After this of funeral dire	27. Manner of Deat 1 X Natural 2 \(\text{Accident} \)		28a. Date of inju (Month, Da		Doutpatient b. Time of injury	3 □ DOA 28c. Inju	4xxx Nurs ryat	28d. Desci		6 Other (Speci	fy)
al or Attending P s after death. I Director: After the in by the funeral Certificate:	3 Suicide 4 Homicide	6 Could not determine	be 28e Place of Ini	ury - At home c. (Specify)	e, farm, street	factory, office			on (Street r Town, St	and Number or Rur ate)	al Route Number,
he Hospita in 24 hours he Funeral pleted filled	29a. Certifier (Check 2 only one)	Certifying Place Medical Exa Certifying No	nysician: To the best of miner: On the basis of e urse Practioner: To the	my knowled examination ar best of my kr	ge, death occ nd/or investiga nowledge, dea	ured at the tim tion, in my opin th occurred at t	e, date and pla ion, death occu ne time, date ar	ace, and due to the arred at the time, on and place, and due	ne cause(s) late and pla to the caus	and manner as sta ace, and due to the c se(s) and manner as	ted. ause(s) and manner stated stated.
within to the state of the stat	29b. Signature and	title of certifier	2mm	200C	RUF	29c. Licens	se number	67	29d.	Date signed (Month	, Day, Year)
	30. Name and addi	ress of person who Gemmell,	completed cause of c	leath (Item 23 3160	Ba) (Type, Prin Gracef	ield Ro	ad, Si	lver Spi	ing,	MD 20904	
State Registrar	31. Date filed (Mont	th, Day, Year) N 19 201	2 Registr	ar's Signature	park	7.					

DHMH 17 Rev 7/2009

State of Maryland / Department of Health and Mental Hygiene

for State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 24, 2012 6:15 PM January Phyllis Fueglein Weber Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Wilson Health Care Center Gaithersburg Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** (Month, Day, Months Hours 404-12-4126 Director 92 1 🗆 M 2 🕱 F Sept. 11,1919 Kentucky 28a-f shov 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits notified at Director Maryland Montgomery 1 Yes 2 No Gaithersburg 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? must be items 23a Funeral 415 Russell Avenue, #1006 20877 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Armed Forces? Black, White, etc. ö þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: "natural", 3 Widowed 4 Divorced Specify: Completed White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Office Manager Oil Company Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) should be file and Mental F is marked of Henry Joseph Fueglein Leona Zimlich other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ge 1 and 2 short of Health a Russell Eugene Weber (Spouse) 415 Russell Ave., #1006, Gaithersburg, MD 20877 20b. Place of Disposition (Name of cametery, crematory or other place)
Montgomery
Crematory 20a. Method of Disposition 20c. Location - City or Town, State January 25 permit. Page 1 Department of Important: If it any injury or o 1 Burial 2 X Cremation 3X Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2012 Alexandria, Virginia 21. Signature of Funeral Service License DeVol Funeral Home, 22. Name and Address of Facility 10 E. Deer Park Drive, Gaithersburg, MD 20877 M01116 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final d Death Ph sician/ Pulmonary Fibrosis years disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Chronic Obstructive Pulmonary Disease years Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 🖾 No Day Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy certificate ha perform 1 ☐ Yes 2X No 1 Yes 2 No To the Hospital or Attending Physician: Be 25. Was case referred to medica 26. Place of Death (Check only one) Hospital Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No ျ 1 Inpatient 2 I ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work?
1 \(\sum \) Yes 2 \(\sum \) No 1 X Natural 5 Pending injury within 24 hours after death.

To the Funeral Director: Aft completely filled in by the fur Accident М Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifie (Check Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature nd title of certifier 29d. Date signed (Month, Day, Year) D19294 January 25, 2012 W address of person who completed cause of death (Item 23a) (Type, Print) Melnick, M.D., 911 Russell Avenue, Gaithersburg, Maryland 20879 31. Date filed (Month, Day Year) State JAN 26 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		•	For State Grant Registrar		ertificate of L			leg. No.	2 03904				
	Physicia		Decedent's Name (First, Middle, Last) Dan M. Winn				2. Date of Deat Month	th 20/2 Year	3. Time of Death /6 45 P M				
	Medic Examin		4a. Facility Name (if not institution, give street and number) PENISSUM KAJONAL MEDICAL	Marker	4b. City, Town, or	Location of Death	/	4c. County of Dea					
4	Funeral Director		5. Social Security Number 6. Sex 7. Age	(In yrs. last birthday,) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	9. Bi	irthplace (State or Foreign ountry)				
		ır		Yrs. 35 10c. City, Town or L	ocation		10 08 1	926 Okl	ahoma 10d. Inside City Limits				
	Maryla 28a-f s otified	Director	Maryland Wicomico	Salisbury					1 Tes 2 X No				
	with the 23a or ust be n	Funeral D	10e. Street and Number 7010 Ashworth Court		10f. Zip Code 21804			10g. Citizen of What C USA	country?				
396	ould be filed within 72 hours after death with the Maryland of Mental Hygiene. marked other than "natural", or items 23a or 28a-f show matic event, the Medical Examiner must be notified at	þ	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Evarmed Forces? 1 Mes Pecedent Evarmed Forces	No	Was Decedent of Hill If Yes, specify Cubar		ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi Specify: Wh	te, etc.				
21215-0036	72 hours 1 "natur Iedical I	Completed	15. Decedent's Education (Specify only highest grade completed)	16b. Kind of Business									
212	l within ygiene. her thar t, the M		Elementary/Secondary (0-12) College (1-4 or 5-10)	F)	DO NOT use retired) ness Owner	:		Ceramic Ti	les				
Maryland	be filed lental Hi rked otl	To Be	17. Father's Name (First, Middle, Last) John M. Winn			18. Mother's Nam Estella	e (First, Middle, N Lynch	flaiden Surname)					
Mary	she han 7 is trau		19a. Informant's Name/Relationship (Type, Print)	1.0	-			City or Town, State, Z	· ·				
	1 and of Healt item 2		Carmela Winn wife 20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ Removal from State	20b Place of Disc	position (Name of			, Maryland 20c. Location - City o					
Baltimore,	Pa ant ant ury		4 Donation 5 Other (Specify) 21. Signature of Fuperal Service Licensee	-	ematory or other place leaven			Dagsboro,	DE				
Ra	permit. Departr Import. any inj		1/2/ 15las	5		III Ka.,	Salispur	y, Marylan	nd 21804				
~-[23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) A Due to (or as a consequence of):												
	Examiner		Carch	consequence of):	en Recide	nt							
	ted ansit	Examiner	cause. Enter Underlying Cause (Disease or injury	consequence of):									
	ificate be executed g physician and as the burial-transit	cal Ex	that initiated events resulting in death) Last C. Due to (or as a	consequence of):									
09/89	tificate I	Medical	IF FEMALE:										
. Box o	To the Hospital or Attending Physician: The law requires that the death certivation 24 hours after death carrivations that the confinement of the Luneral Director. After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use.	Physician/M	23b. Was decedent pregnant 23c. If yes, outcome o	Petal death 3	☐ Ectopic pregnancy ☐ Other (specify)	у		23d. Date of de Month	elivery Day Year				
7.	ss that the igned by be deta	ρ	Part II. Other significant conditions contributing to death bu	t not resulting in the	underlying cause give	en in Part I.		acco use contribute to					
ords	w requir s been s 2 should	Completed					24a. Was ar	24b. Were au	Probably 4 Unknown				
Vital Records,	r: The la icate ha r, page		DC W			-	autops perform 1 \square Yes 2	ned? death?	completion of cause of				
VITA	hysiciar his certif Il directo	To Be		nt 2 🗌 ER/Outpatie	ent 3 DOA Othe	r: 4 Nursing Ho		nce 6 🗆 Other (Spec	cify)				
TO UC	nding Path. r: After tl	icate:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident Investigation		work?		28d. Describe hor	w injury occurred					
DIVISION	ital or Atte irs after de al Directo lled in by th	al Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injurbuilding, etc.	y - At home, farm, st (Specify)	treet, factory, office		28f. Location (Str City or Town,	reet and Number or Ru , State)	ural Route Number,				
:	ne Hosp n 24 hou ne Funel	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of more consistent of the best of	amination and/or inve	stigation, in my opinior	n, death occurred a	the time, date and	d place, and due to the	cause(s) and manner stated.				
	To the within the complete com		29b. Signature and title of certifier		29c. License		29	9d. Pate signed (Mont					
	5.6		30. Name and address of person who completed cause of dea	ath (Item 23a) (Type,				MA 3	1801				
	Stat Registra		MISZUS. Buig MP 31. Date filed (Month Ash) 1995 2012 32 Segistrar		East Coll	011 5.	1113001	1110 3	100				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month DONNA L. WILLEY 2 01 2122 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death SALISHIA HICOMICO MIDNAL If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Funeral Security Number Age (In vrs. last birthday) 9. Birthplace (State or Foreign DELAWARE 221-28-0467 **Director** 1 □ M 2 🛛 F 68 SEPT. 21,1943 show 10a. State at 10c. City, Town or Location 10d. Inside City Limits Director must be notified 28a-f WORCESTER MARYLAND BISHOPVILLE 1 🗆 Yes 2 🗶 No 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 10207 HOTEL ROAD 21813 USA ral", or items 2 Examiner mus death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Bace - American Indian Armed Forces?

1 Yes 2 X No þ 1 Never Married 2 Married 1 Yes If Yes, Give Maryland 21215-0036 be filed within 72 hours after 1 Yes 2 XNo Specify. "natural", Completed 3 X Widowed 4 Divorced Year or Dates WHITE other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 BRANCH MANAGER BANKING Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) marked ည WILLIAM THOMAS IRIS MAHONEY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) if Health a JAMES DOUGLAS WILLEY/SON 10207 HOTEL ROAD, BISHOPVILLE, MD 21813 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Page 1 Important: If it any injury or o 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) BISHOPVILLE CEMETERY 1/26/12 BISHOPVILLE, MARYLAND Signature 22. Name and Address of Facility HASTINGS FUNERAL HOME, SELBYVILLE, DE. 19975 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. nterval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Examine Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? Other (specify) Pregnant at time of death ed by the a g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an the Hospital or Attending Physician; The law autopsy performed? 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 2 No. မှ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, Funeral Director; After thi stely filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 \quad Yes 28d. Describe how injury occurred Certificate: Natural 5 Pending iniury 2 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the I 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20001 Bennett PRMC

DHMH 17 Rev 06-2011

Registrar

JAN 25

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician/ Joyce Elaine Warnick Medical 4a. Facility Name (if not institution, give street and number, Examiner 4c. County of Death Western Maryland Regional Medical Center Cumberland Allegany 5. Social Security Number **Funeral** 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country) Maryland Days Hours (Month, Day, Year) August 17, 1944 Min. 219-44-2327 Director 1 🗆 M 2 💢 F or 28a-f show be filed within 72 hours after death with the Maryland notified at 10b County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Allegany Lonaconing 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be Funeral items 23a 79 Jackson Street 21539 **USA** 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner ō Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify "natural" 3 Widowed 4 Divorced White Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 12 Homemaker Home traumatic event. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, and Mental F permit. Page 1 and 2 should be 1 Department of Health and Mental Important: If item 27 is m-any injury or otho-၉ Harry Eugene Airesman Frances Lee McDonald 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kenneth Warnick, Sr., - Husband 79 Jackson Street, Lonaconing, Maryland, 21539 20a, Method of Disposition 2Cb. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State February 06 1 Burial 2 Cremation 3 Removal from State **Cumberland Crematory** 2012 Cumberland, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Eichhorn-McKenzie Funeral Home P.A 8 East Main Street Lonaconing, MD 21539 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph sician/ atheroscircitic disease or condition Medical resulting in death) Due to (or as a consequence of **Examiner** Sequentially list conditions Examiner cause. Enter Underlying Cause (Disease or injury that initiated events Disk to for es a nonsconence or To the Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Month Pregnant at time of death Day Year been signed by the a should be detached g Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed After this certificate 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 Yes 2 No Other ျ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury 1 Yes 2 No Accident Investigation
6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a

To the Funeral I Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of e (Check amination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certi 29c, License number 29d. Date signed (Month, Day, Year) 16

ABM

State Registrar mn9

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kramadit

1 0 2012

31. Date filed (Month, Day, Year

Ponai

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Feb 1 2012 Wharton 5:15 PM^M LaVerne Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Allegany Allegany Health Nur. & Rehab. Ctr. Cumberland If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. Birthplace (State or Foreign Country)
 MD Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Date of Birth 1 M 2 DF Month, Day Director 218-12-5084 89 Usual Residence of Deceden or 28a-f shov 10a. State 10c. City, Town or Location injury or other traumatic event, the Medical Examiner must be notified at Director 10d. Inside City Limits MD Cumberland Allegany 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 23a Funeral 730 Furnace Street 21502 USA items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? 0 1 Never Married 2 Married Black, White, etc. by permit. Page 1 and 2 should be filed within 72 hours after or Department of Health and Mental Hygiene. If item 27 is marked other than "natural", or Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates 3 Divorced 4 Divorced Specify. Completed white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Nursing Assistant Memorial Hospital Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Nora Rice Harry Wharton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Jean Morgan MD 21502 niece 423 Pennsylvania Ave. Cumberland Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Restlawn Memorial Gardens 2/6/2012 LaVale MD 4 Denation 5 Other (Specify) Agnatur of Funeral Service Licensee 22. Name and Address of Eacility
Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Ph_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of) and I-transit Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and resulting in death) Last Due to (or as a consequence of): burialphysician the burial Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Pregnant at time of death 5 Other (specify) Month Dav Year as been signed by the a Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page ; performed? Yes 2 No this certificate 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) examiner? Hospital 2 🗹 No Other: ပ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural work?
1 Yes 5 Pending 2 🗌 No the Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time. date and place and due to the cause(s) and manner stated. Medical 29a. Certifier

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

Sr.M.D. 200 Glenn St

29d. Date signed (Month, Day, Year)

RD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Maria Zwirn Jan 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Crofton Crofton Care Center Anne Arundel If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Mar. 9, 1926 Social Security Number 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign **Funeral** 1 M 2 X F Hours Director 082-34-5662 85 Usual Residence of Decedent Silvens or marked states and states are states and states or 28a-f show it is marked other than "natural", or items 23a or 28a-f show it is marked other than "natural", or items 23a or 28a-f show it is marked other than "natural", or items 23a or 28a-f show it is marked other than "natural", or items 23a or 28a-f show it is marked or items and it is not a shown in the marked or it is not a shown in 10h. County 10c. City, Town or Location 10d. Inside City Limits Director MD Anne Arundel Crofton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1304 Persimmontree Ct. 21114 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. þ Yes 2 X No Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White Completed 3 X Widowed 4 Divorced Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Florien Mair Maria Zehetner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr Gloria Marsella / Daughter 1463 Leas Way, Hatfield, PA 19440 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Durial 2 La Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Kalas Crematory Other (Specify) 1/25/2012 Edgewater, MD 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd., Edgewater, MD 21037 er the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Due to for as a consequence of if any, leading to immedia cause. Enter Underlying Cause (Disease or iinjury and -transit requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last physician a s the burial-Physician/Medical attending pt IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death Dav 1 Yes 2 9 Unknown 4 ☐ Pregnant
9 ☐ Unknown detached s been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 2 🗌 No

Box 68760 P.O. Records, or Attending Physician: The law **Division of Vital** filled in by

Completed by performed Yes 2 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 19 No 1 Tes Other: ျှ 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27, Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital or within 24 hours at To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practione: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number R 135100

Aliahan Blup. Glen Burnie My

10:00 AM

Austria

1 ☐ Yes 2 🛣 No

Year

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Doris Physician/ May Ashburn Dav Feb 2012 Medical 5:40 A 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Hospice Center Towson Baltimore 5. Social Security Number . Age (In yrs. last birthday) **Funeral** If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) Months Davs Hours Min (Month, Day, Year) 218-18-2939 **Director** 88 1 ☐ M 2XXE Yrs. June 19,1923 Usual Residence of Decedent Maryland with the Maryland 10a. State 10h County 10c. City, Town or Location Director 10d. Inside City Limits notified 28a-f Maryland 1 Yes 2 No Baltimore Dundalk 10e, Street and Number must be 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 101 Center Place Apt. 717 21222 United States items 2 permit. Page 1 and 2 should be filed within 72 hours after death to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, þ 1 Never Married 2 Married Black, White, etc. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: 3 Widowed 4 □ Divorced Completed Specify: Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 11 Years Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Charles O. Wolf Rachel Popp 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael L. Ashburn(Son) 103 Belvedere Ave. Glen Burnie, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ★ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place. 4 Donation 5 Other (Specify) Sacred Ht. of Jesus Cem2/9/2012 Dundalk, Maryland f Funeral Service Licensee 21. Signat Duda-Ruck Funeral Home of Dundalk, 7922 Wise Ave. Dundalk, MD 21222 23a. Part 1. Enter the disease or complications that caused shock, or help failure. List only one cause on each line or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition resulting in death) Medical e to (or as a consequence **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause (Disease or injury that initiated events Due to (or as a consequence of): executed resulting in death) Last Due to (or as a consequence of): the burial Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 ding IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ þ in the past 12 months? Pregnant at time of death signed by the at d be detached for Month Day 2 3 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed should 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has page 2 autopsy performed? Yes 2 W funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 1100 မ 1 Yes Other: 1 Inpatient 2 ER/Outpatient 3 IDOA After this 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending s after death.

I Director: Aft
d in by the fur Accident Investigation 1 Yes Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined To the Hospital within 24 hours a To the Funeral C Medical Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature ar 29c. License number 29d. Date signed (Month, Day, Year)

10 V

State Registrar Date filed (Month, Day, Year,

FEB 1

NCHARI

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3 2012

701

710

AMEND - Jype or Print in Black լրվցիթի իրեւ Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month BOHRER. Physician/ ANIEL 1:00 P.M 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death MONTGOMFRY GOVERAL HUSPITA O LNEY MONTHOMERLY 7. Age (In yrs. last birthday) If Under If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** 1 M 2 □ F **Director** 06/07/1923 28a-f show 10c. City, Town or Location 10a. State death with the Maryland iral", or items 23a or 28a-f sho Examiner must be notified at 10d. Inside City Limits Director MUNTGOMERY MD DLINEY 1 Yes 2 No 10f. Zip Code 10g. Citizen of What Country? WAKER LAWE, SANDYSPAINTS Funeral MP: USA 12. Was Decedent Ever in U.S.
Armed Forces?
1 Ayes 2 No 1942-13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify Specify: WHITE "natural", Completed 3 Divorced 4 Divorced 1944 Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than ' Elementary/Secondary (0-12) College (1-4 or 5+) the soil chemist Dept of Agriculture Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Emma Alberttene Barnett Elijah Irvin Bohrer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Daniel W. Bohrer - son 4531 Hickory Lane; Mt. Airy, MD 21771 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 22. Name and Address of Facility State Anatomy Board Director 655 W. Baltimore St; Baltimore, MD 21201 Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final ARTENJOSCUTROTIC CEREBIONASCUAL Physician/ disease or condition resulting in death) CHIVION Medical Due to (or as a consequence of) Examiner Se wentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Day Year Pregnant at time of death g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ADVANCED CHROMI OBLITAVED VE 1 Yes a No 3 Probably 4 Unknown VUMPNAMY DISPAIS, CONGEDING HEALT FAIWER 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an PROSTATIC HYPERTOLOGY ATMAL FIBRILLADON: 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Yes Hospital Other: 2 🗌 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Spec 28c. Injury at work? 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred Natural iniury 5 Pendina 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completely filled in by determined 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F 29d. Date signed (Month, Day, Year) - Smandun 1)53367 2-1-12 SHYAM SUNDAR RADAN 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SV115:117 SILVON SPRING MD: 20902

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ January 30°, 201^Y2^{aı} 11:10 P_M Thomas Brooks Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Washington Adventist Hospital Takoma Park Montgomery If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Dec 3, 1933 Birthplace (State or Foreign Country) Unk **Funeral Director** 1 🕅 M 2 🗆 F 577-44**-**3003 78 Usual Residence of Decedent 28a-f show 10a. State 10b. County Ħ 10c. City, Town or Location 10d. Inside City Limits Director notified MD Prince Georges College Park 1 🗆 Yes 2 🖁 No 10e. Street and Number 10g. Citizen of What Country? ò $\overset{\text{Zip Code}}{20740}$ ıral", or items 23a o Examiner must be Funeral 9227 Limestone Place permit. Page 1 and 2 should be filed within 72 hours after death a Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu 11. Marital Status unk Was Decedent Ever in U.S.unk
 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc Completed by 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify If Yes, Give Year or Dates black 3 Widowed 4 Divorced Specify. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation unk 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) unk unk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Yolanda Rich - daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 \square Burial 2 \square Cremation 3 \square Removal from State 4 \square Donation 5 N Other (Specify) in state cemetery, crematory or other place, roral Se Kona 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore St; Baltimore, MD Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ ARDINAZ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine ASDOMINA attending physician and I for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Year Day ☐ Pregnant at time of death☐ Unknown signed by the at d be detached f 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Unknown plnous 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has autopsy perform certificate 1 ☐ Yes 2 ♣No 1 Yes To the Hospital or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 Yes 2 1 No Other: မ 1 I Impatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at : After 28d. Describe how injury occurred 5 \square Pending Natural injury hours after death. 1 Yes 2 No Accident Investigation 6 Could not be within 24 hours after deat To the Funeral Director: Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Ammen 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHAD SHAMIM WASHINGTOW ADVENTURT HOSP, TANOMA 31. Date filed (Month, Day, Year) State FEB 1 3 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death ecedent's Name (First, Middle 2. Date of Death 3. Time of Death Physician/ Month Day 4:25A.M Medical 4a Facility Name (if not institution, give City, Towh, or Location of Death Examiner County of Death Howen If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign (Month, Day, March 5 345-28-4942 1 🛛 M 2 🗆 F Months Days Hours 1936 Country) Illinois Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1√2 Yes 2 □ No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21229 USA 10 N. Rock Glen 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? 1 Yes 2 No If Yes, Give Black, White, etc. 1 Never Married 2 Married 2 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify. white 3 Widowed 4 N Divorced Specify: Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 0 laborer factory work Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk ည 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number of Rural Boute Number, City or Town, State, Zip Code) Roslyn Cooley-Prayer-guardian 611 Central Ave: Towson, MD 21204 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Xother (Specify) in state cemetery, crematory or other place) 22. Name and Address of Facili Ronald S. Walter Director 655 W. Baltin 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as shock, in heart failure. List only one cause on each line. Immediate Ca. Et disease or condition resulting in death) 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore St; Baltimore, MD 21201 Approximate Interval Between Onset and Death Physician/ Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): burial-transit Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Dav Pregnant at time of death detached g 🗌 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed I 23e. Did tobacco use contribute to the cause of death? Completed by Records, The law requires 1 🗌 Yes 2 No 3 Probably 4 1 Unknown page 2 should 24b. Were autopsy findings available 24a. Was an nas autopsy death? certificate 2 No within 24 hours after death. To the Funeral Director: After this certifice completed filled in by the funeral director, t Physician: 25. Was case referred to medic of Vital Be 26. Place of Death (Check only one) examiner? 2 Other: ပ္ 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Inpatient 2 🗎 ER/Outpatient 3 🗌 DOA 27. Manner of De Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred or Attending work? ura 5 Pending injury Division 2 No ccident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

To the Hospital

State Registrar

(Check only one) 29b. Signature and title of certification

31. Date filed (M

3 2012

DHMH 17 Rev 7/2009

23a) (Type, Print)

Farks

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible ink JEnsure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 Shirley Blair-Murray February 3:40 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Southern Maryland Hospital Clinton Prince Georges If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) uly 20, 1934 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours Director 229-42-5907 1 □ M 2 □XF 77 Virginia 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director notified 28a-f 1 🗌 Yes 2 🖵 No MD Prince Georges Capital Heights 10e. Street and Number 10g. Citizen of What Country? ms 23a or must be r Funeral 5001 Lee Jay Ct. 20743 USA items (ı "natural", or iten ledical Examiner n Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Yes 2 X No Page 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene.

The 17 is marked other than "natural", or sure 17 it marked other than "natural", or other traumatic event, the Medical Exami Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify black Completed 3 Widowed 4 X Divorced Specify: 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Macy's salesperson Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Cora Ruff Eldridge Blair 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 5001 Lee Jay Ct; Capital Heights, MD 20743 James Blair - brother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of H Important: If ite any injury or oth 20c. Location - City or Town, State 1 Burial 2X Cremation 3 Removal from State 2-14/2012 Glen Burnie, Md 4 ☐ Donation 5 📉 Other (Opecify) in gtate Atlantic Cremayory Signature of Uneral Service Lice Thomas 22. Name and Address of Facility State Anatomy
Simplicity Cremation Service
All W. Baltimore St. Baltim 7090 Ridge Rd Hanover, Mary Land nter the disease, or complications that caused heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final .Ph. sician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine NENERALIZED and Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical P.O. Box 68760 the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Dav Pregnant at time of death Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform hours after death. uneral Director: After this certificate h 1 Yes Yes To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Tes 2 Inpatient 2 ER/Outpatient 3 DOA 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) funeral 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred Natural Accident 5 Pending injury 1 Yes 2 No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number determined City or Town, State) within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check

State Registrar 29b. Signatore and title of certifier

son who complete

e of death (Item 23a) (Type, Print) 7503

Certifying Nurse Practitione. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

SURRATTS

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. and #8 Pet FH C924 2/13/2012 JH State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day}9,20°12 Physician/ February 1:45P.M Nellie W. Bahner Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Baltimore City 1716 East Pratt Street Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) May Year) **Funeral** 220-22-4360 Usual Residence of Decedent **Director** 1 🗆 M 2 🔀 F 23,1927 Mar Maryland 84 28a-f show 10a. State 10d. Inside City Limits notified at 10b. County 10c. City, Town or Location Director Md. Baltimore City 1X Yes 2 ☐ No 10e, Street and Number 10f. Zip Code ò 10g. Citizen of What Country? ian "natural", or items 23a or Medical Examiner must be Funeral 21231 U.S.A. 1716 East Pratt Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2X No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 XNo Specify. Specify. 3 ₩ Widowed 4 □ Divorced Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) filed within 72 al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the 8th Home Maker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental is marked o Department of Health and Mente Important: If item 27 is marked any injury or other trees. Thomas Gallup Justina Kope 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1716 East Pratt Street Baltimore, Md.21231 Vernon T. Bahner- Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State February 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Garrison ForestVA 17,2012 Owings Mills, Md. 4 Donation 5 Other (Specify) M00933 22. Name and Address of Facilit Kaczorowski Funeral Home, 21. Signature of Funeral Service Licensee 1201 Dundalk Avenue Baltimore, Md.21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician disease or condition Medical resulting in death) **Examiner** ABETES MELLITUS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine PERTENSION and resulting in death) Last attending physician for use as the buria Physician/Medical certificate be P.O. Box 68760 as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Day Month Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 1 ☐ Yes ∠ ☐ 9 ☐ Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perforr Yes Physiclan: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5X Residence 6 Other (Specify) Hospital 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral directors. 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: To the Hospital or Attending 1 XNatural 5 Pending work? 1 Yes 2 No filled in by the 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29c. License number

Registrar
DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year)

Savinder K. Julka, M.D. 2 Market Place Dundalk, Md. 21222

D 27188

February 10,

2012

du 16 Tullea MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

12-01099 Charles Bradley	Day		or Print in Blac						gible.			
Charles Brauley		7111311 STATE	e of Maryland / [nent of He cate of De		d Mental I	Hygiene	201	2 0391		
Physicia		Registrar 1. Decedent's Name (First, Middle,La	ast)	OCILIII	cate of be	attr	· · · · · · · · · · · · · · · · · · ·	2. Date of Deat	eg. No.	3. Time of Death		
Medical Exami		Charles Brad	lley Bowman	n, Sr.				Month February 6	Day Year 5, 2012	1527 hrs		
		 Facility Name (if not institution, g South Clear Ridge R 			1	ty, Town, or w Winds	Location of Dea Or	ath	4c. County of Death			
Funeral		Social Security Number 6. 9	Sex 7. Age (in yrs. last b		Inder 1 Yea			th(MM/DD/YYYY) 9. Bir			
Director		212-68-8488 1 [X м 2 F	55	Yrs. Mo	onths Day	s Hours M	Dec. 1	12, 1956 CountMaryland			
any		10a. State 10b. County	10	c. City, Tov	vn or Location		- in			10d. Inside City Limits		
▶	ţ	Maryland Carr	oll	1	New Wind					1 Yes 2 No		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a ar 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	Director	10e. Street and Number 120 S. Clea	r Ridge Rd.		10f.	Zip Code	21776	10	10g. Citizen of What Country? U.S.A.			
th with tems 23	Funeral	11. Marital Status 1 Never Married 2 Marrie	12. Was Decedent Ev						- 14. Race - Ameri White, etc.	can Indian, Black,		
ifter dea	by Fu		1 Yes 2 X ed If Yes, Give Year or Dates:	No	1 Yes	2 X No	specify:		Specify: V	White		
ours a	B D	15. Decedent's Education (Specify	only highest grade comple		a. Decedent's Usi		ion (Give kind o DO NOT use re		16b. Kind of Business/I	ndustry		
36 in 72 h	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)					strictly	- -			
1 with giene	E	12 17. Father's Name (First, Middle, Las	st)		TOLK I	_	perator	ne (First, Middle, M	stair mfo]•		
215 tal Hy rt th	Bec	John Blanchard	•					Isabelle	•			
21, ould b d Men	2	19a. Informant's Name/Relationship	(Type, Print)	1	9b. Mailing Addr	ess (Stree	_		ber, City or Town, State	, Zip Code)		
MD and 2 sh lith and 1 in 27 in auman		Tina Spielman/si	ster-in-law		407 E.				neytown, MD			
or Hear of Hear tr		20a. Method of Disposition 1 X Burial 2 Cremation 3	Removal from State	crem	e of Disposition (I atory or other pla	ace)		Date	20c. Location - City or	Town, State		
t. Pag tment tment:		4 Donation 5 Other Specification 21. Signature of Funeral Service Lice		Meth	nodist C			/10/2012	Middlebu			
Bal permi Depar injur		atharine C.	La Do		22. Name a		110		Tuneral Home			
Physician	\dashv	23a. Part I. Enter the disease, or com		e death. Do	not enter the mod	Broad de of dying,	JWa.V such as cardiac	or respiratory arre	ridge, MD 2° est, shock, or heart	Approximate Interval		
/Medical		failure. List only one cause on a Immediate Cause (Final disease	each line. _{a.} Atherosclerotic Ca	ardiovaso	ular Disease					Between Onset and Death		
LXammer		or condition resulting in death)	Due to (or as a consequ	ence of):								
	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a consequ	ence of):								
	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):										
E and Sca	cal E	- ,	d									
		IF FEMALE:	AMENDED 23c. If yes, outcome	of pregnanc	<u>.</u>				23d. Date of delivery			
cath certifica eath certifica attending pl	an/	23b. Was decedent pregnant in the past 12 months?	1 Live birth		2 Fetal dea	ath 3 [Ectopic pregr	nancy		ay Year		
Box te death c the atten	Physician/Med	1 Yes 2 No 9 Unknow	4 Pregnant at tim 9 Unknown	e or deatri	5 Other (S	specify)						
ords, P.O. I w requires that the as been signed by the should be detached	by P	Part II, Other significant conditions	contributing to death but	ut not result	ing in the underly	ring cause g	iven in Part I.		bacco use contribute to			
S, F uires t uires t Id be c		Chronic Alcohol Use							2 No 3 Prob	,		
Cord law rec	Completed							24a, Was a autops perfor	y prior to c	topsy findings available ompletion of cause of		
tal Rec	녌		<u> </u>					1 ✓ Yes 2		s 2 No		
Vital Pysician: this certific director,	BB	25. Was case referred to medical examiner?	Hospital: 1 Inpatient	2 FR/	Outpatient 3		of Death (Check		Residence 6 🗸 Other	Scope		
n of Vi ding Physi a. After this	밝	1 ✓ Yes 2 No 27. Manner of Death	28a. Date of Injury	281	. Time of Injury		y at Work?		ow injury occurred	. 000110		
Sion Attendin death. ector: A	atior	1 Natural 5 Pending 2 Accident Investiga	(Month, Day,Year)	'		1 Y	es 2 No					
Division of Vital Records, P.O. pital or Attending Physician: The law requires that the ours after death. reral Director: After this certificate has been signed by filled in by the funeral director, page 2 should be deach	Certification:	3 Suicide 6 Could no	t be 28e. Place of Injury	y - At home,	farm, street, fact	ory, office b	uilding, etc.	28f. Location (S or Town, St	treet and Number or Ru ate)	al Route Number, City		
Division Hospital or Attental to the desired or the desired by Funeral Director tely filled in by the		4 Homicide	cian: To the best of my kr	nowledge d	leath occurred at	the time da	te and place ar	nd due to the cause	e(s) and manner as state	ed.		
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burn	Medical	one) 2 Medical Examine	er:On the basis of examin and manner stated.		r investigation, in	my opinion	death occurred		and place, and due to the	e cause(s)		
	2	29b. Signature and title of certifier	200			29c. Licenso O.C.I			29d. Date signed (Mor			
6 811	-	30. Name and address of person who	completed cause of deal	th (Item 23a		0.0.1	**· ha.					
ار ک		Patricia Aronica-Pollak M	D. Assistant Med	dical Exa	miner 900		nore Street,	Baltimore, MD	21223			
Sta Regist	ate rar	31. Date filed (<i>Month, Day</i> , Year) FEB 1 3 2	32. (legistrar's :	Signatur	park	1						
			4		-							

DHMH 17 Rev 1/2001

OCME

		For State	State of	Marylan		artment of H rtificate of D		Mental Hy	/giene Reg. No. 2	012	03916
		Registrar 1. Decedent's Name (First, Management)	Middle, Last)					2. Date of D	eath	U I C	3. Time of Death
Physi- /Med		Janie Del	lia Byrd					02	0 7	2012	1:200 M
Exam		4a. Facility Name (If not insti				4b. City, Town, or		th		unty of Death	1
not le		Future Care 5. Social Security Number		1 7. Age <i>(In yrs. I</i> .	last hirthday)	Baltime If Under 1 Year	ore If Under 24 Hrs	s. 8. Date of B	N/		nplace (State or Foreign
Funera Directo		258-48-0874	1 M 2 THE	7. Age (<i>III yis. I</i> i	Yrs.	Months Days	Hours Min	. (Month, L	2/1934	COL	abama
ъ		Usual Residence of Deceder	nt					0.7	.,		
arylar show	7	10a. State 10b. Co		10c. City	y, Town or Lo						10d. Inside City Limits 1 Yes 2 No
the M	recti	MD 10e. Street and Number	N/A			Baltimo	ore		10a Citizen	of What Cou	
3a or	Ö	6037 Lanett	te Rd.			2120	6		U.S.		,
death	Funeral Director	11. Marital Status	12. Was Deced		S. 13.	Was Decedent of Hi If Yes, specify Cuba		Specify Yes or N		Race - Amer	
36 after		1 Never Married 2	Married 1 ☐ Yes 2	No P	1	1 □Yes 2 □ No	Specify:	rto rticari, etc.)		Black, White	
d 21215-0036 filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show ant, the Medical Evantian court by noulthed at	ed by	3 Widowed 4 □ Divo	edent's Education	tes:		dent's Usual Occupa	ation			ecify: Bla of Business/II	
215	Completed	(Specify only h	nighest grade completed)	dor 5 i	(Give life.	kind of work done d DO NOT use retired,	furing most of wo	orking		. 24011,000.1	, addity
212 d with giene /giene er tha	E C	6th Grade	(12) College (1-s	401 5+)	Hou	sekeepe			Sel		
Ind be file tal Hy d oth event	Be	17. Father's Name (First, Mic						me (First, Middl			
Maryland d 2 should be file tith and Mental Hy 77 Is marked othe traumatic event.	ဥ	George Wesl	-		405 14-11-	ng Address (Street a		ie B. V			in Codol
Mal d 2 si lith an lith an 27 Is r		19a. Informant's Name/Rela Janet Cook				Lanette					
s 1 ar of Hea		20a. Method of Disposition	, add gireez ,	20b. P		sition (Name of natory or other place		Date		ion - City or T	
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exactor or that be multihed at		1 Burial 2 □ Crema 4 □ Donation 5 □ Oth	ition 3 □ Removal from Si ier <i>(Specify)</i>	iaie i	klawn			/15/12	Balt	imore	e, MD
Balti permit. Departr Importa	į	21. Signature of Funeral Ser	rvice Licensee	<u> </u>	22	Name and Address Joseph H	s of Facility Brow	n Jr.	Funera	al Ho	me PA
n 28 5 5	N .		U 13		21	40 N. F	ulton	Ave.,	Baltir	more,	MD21217
		23a. Part 1. Enter the diseas shock, or heart failure. Immediate Cause (Final	se, or complications that ca List only one cause on ea	used the death ch line.	n. Do not ent				arrest,		Approximate Interval Between Onset and Death
Physician / /Medica	_	disease or condition resulting in death)	a	or as a consequ	ry 10	ray	Oisio	(SI			
Examine	•		Due to (o	or as a consequ	denda or).						
	ner	Sequentially list conditions,	b. Due to (c	or as a consequ		_					
ecuter and transi	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	с								
58760, ficate be executed physician and s the burial-transit	E E	resulting in deathy East	Due to (o	or as a consequ	Jence or):						
587 ficate p phys	edical		d	-							
Box 6 death certific attending p	IN/M	IF FEMALE: 23b. Was decedent pregnar	at 23c. If yes, outcome			76			23d	l. Date of deli	very
P.O. BOX at the death cer at by the attendin stached for use.	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No		irth 2□Fetal ant at time of d		☐ Ectopic pregnancy ☐ Other <i>(specify)</i>	/			Month	Day Year
dS, P.O. I uires that the de signed by the a	by Physician/M	9 ☐ Unknown Part II. Other significant co			ulting in the co	ndarkina anusa aku	on in Dort I	23e Dio	I tobacco use	contribute to	the cause of death?
dS, ires the signer	þ		unditions contributing to dea	ain bui noi resi	utting in the u	ndenying cause give	en in Part I.				obably 4 ☑ Unknown
cord w requir	Completed	- FIGPOCO						24a. Wa			topsy findings available
on of Vital Red ding Physician: The lav h. After this certificate has funeral director, page 2 !	mg							- aut _ per	opsy formed?	prior to death?	completion of cause of
ital an; T tifficat tor, pe	Be Co	25. Was case referred to me	ədical				26. Place of De	1 □Yes eath (Check only		1 ∐Yes	2 D KNo
1 V nysici nis ce direc		examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ In	npatient 2 🗆	ER/Outpatier	nt 3 ☐ DOA Othe	er: 4 Nursing	Home 5 ☐ Re	sidence 6	Other (Spec	oify)
ing Pl	ü.:	27. Manner of Death 1★ Natural 5 □ Po	28a. Date o ending (Month	of Injury h, Day, Year)	28b. Time o Injury	Work		28d. Describe	e how injury o	ccurred	
ISIO ttendi death. ttor; /	cati	ZUACCIGOTIC	ovestigation	of Injury . At ho	mo form etr	M 1 1	Yes 2 □ No	29f Location	(Ctroat and N	lumbar or Pu	ural Pauta Number
Division of Vital Records, for datending Physician: The law requires the after death. Director: After this certificate has been signe in by the funeral director, page 2 should be d	Certification: To	4 ☐ Homicide de	etermined 20e. Flace of building	ig, etc. (Specify	y)	eet, lactory, office			own, State)	idiliber or Ad	ral Route Number,
Division of Vital Records, P.O. Box 68760, for the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. For this certificate has been signed by the attending physician and to the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit			rtifying Physician: To the I dical Examiner: On the ba								
the h thin 24 the F	Medical	29b. Signature and title of ce	and manne			29c. License				igned (Month	
7 × 6 0		TIY	MSICIAN			_	7543			9-12	
		30. Name and address of pe		of death (Item	1 23a) (Type		17 7			, ,	·
		PREETINDE	R SANDHL	LMD	1240	W. BALTI	NORE S	T. BAL	TIMUR	Emp	21223
	tate	PREETINDS 31. Date filed (Month Pax.	3 2012 33 Re	egistrar's Signa	e .	even				/	
Regis	urar"	1 60	100								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND TTEM#5perFH, G924, 2/27/2012, WS State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1 Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Feb. Corine Physician/ Carr 2012 4:51A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Genesis Heritage Nursing Home Dundalk Baltimore If Under 1 Year If Under 24 Hrs. Funeral 2195-281×181162 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Sept. Day,11941, 1932 1 □ M 2 🕮 Days Hours Kentucky 2 - 28 - 816279 Director Yrs Usual Residence of Decedent show 10a, State 10b County 10c. City, Town or Location 10d. Inside City Limits injury or other traumatic event, the Medical Examiner must be notified at Director Middle River Baltimore or 28a-f MD 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? than "natural", or items 23a Funeral United States 21220 10040 Ichabod Lane death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married 2 🔀 No Baltimore, Maryland 21215-0036 72 hours after 1 Yes If Yes, Give 1 Yes 2 No Specify: White Completed Specify: 3 XWidowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Medical Administrative Assistant 12 Years is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Beckham Caudill and Mental ပ Page 1 and 2 should be f ment of Health and Menta Fannie Trent 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
10040 Ichabod Lane Middle River, MD 21220 permit. Page 1 and 2 sh Department of Health a Important: If item 27 is Vicki E. Astarita (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery crematory or other placel 1 ₺ Burial 2 ☐ Cremation 3 ☐ Removal from State 2/8/2012 Baltimore, MD Oak Lawn Cemetery 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Buda-Ruck Fineral Home of Dundalk, Inc 7922 Wise Ave. Dundalk, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examin that the death certificate be executed burial-trans and Physician/Medical Box 68760 attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnapt 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months
1 Yes 2 No Year Month Day Pregnant at time of death
Unknown signed by the a 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobaeco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed DISEASA 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autonsv performed? death? 1 Yes 2 No Yes the Hospital or Attending Physician: 25. Was case referred to medical Be the funeral director, 26. Place of Death (Check only one) Hospital: Other: 2 No 1 Yes 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ပ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural injury work? 5 Pending s after death. 2 🗌 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 - Homicide determined City or Town, State) 24 hours a Funeral I Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one 29b. Signature 29d, Date signed (Month, Dav. Year) 30. Name and addre 5410-A 10V 31. Date filed (Month. egistrar's Signatu State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Cooke, Sr. Physician/ Charles Glenn 3 Day 2012 Year Month Feb. 9:10 M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 405 Wise Ave. Dundalk Baltimore Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday **Funeral** 214-30-4288 Months 1 X M 2 X F **Director** 79 Sept. 28, 1932 Pennsylvania Yrs. Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at Director 1 ☐ Yes 2 🏻 No Dundalk MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 405 Wise Ave. 21222 Hygiene. other than "natural", or items within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Race - American Indian. Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates White 3 ☒ Widowed 4 ☐ Divorced Specify: Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Bricklayer Steel Industry and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Margaret Moore Charles Cooke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ge 1 and 2 sh it of Health an 21222 8213 Shore Road Dundalk, Maryland Lisa Martin (Daughter) 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Page 1 Department of Important: If if any injury or c 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Hilltop Service Corp. 2/8/2012 Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22 Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Dundalk, Maryland 7922 Wise Ave. Inc. 21222 23a. Part 1. Erger the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Immedate Physician/ Cardiac Failure disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner vears Advanced Cardiomyopathy Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) attending physician and I for use as the burial-transit years that the death certificate be executed Cause (Disease or injury Coronary Artery Disease that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year signed by the all Id be detached for P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Renal Dysfunction, Chronic Obstructive Pulmonary Records, 1 Yes 2 No 3 Probably 4 Unknown Completed plnous peen Disease 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 1 this certificate ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 AResidence 6 Other (Specify) 2.X No 1 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural To the Hospital or Attending 5 Pending 1 Yes 2 No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 06-2011

State

1.+1,

Campbell

Baltimore, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

alto

Date filed (Month, Day, Year)

FEB

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		-	For State	State Contificate of Dooth											
			Registrar 1. Decedent's Name	(First, Middle, La:	st)		Cei	incate (JI Deall	1	Reg. No. 2. Date of Death 3. Time of Death				
	Physicia Medic		EHUD	J	CC	HEN					Month FEBRUA	Day 8	Year 2012	M	
pith a tigo	Examir		4a. Facility Name (if r		e street and number)			-	vn, or Locatio				nty of Death		
	<u> </u>		SINAI H 5. Social Security Nu		of Baltin			Balt If Under 1	MORE	er 24 Hrs.			N/A		
	Funeral Director		578-28-4		X M 2 □ F		ast birthday)		ays Hours		8. Date of Bir (Month, Da	y, Year)	9. Birth	place (State or Foreign htry)	
			Usual Residence of	f Decedent		85	Yrs.				02/19	9/1926		DC	
	yland if sho	향	10a. State	10b. County		10c. Cit	y, Town or Loc	ation					1	10d. Inside City Limits	
	e Mar r 28a- notifi	jë	MD 10e. Street and Num	BALTI	MORE		BALTIM		-1-					1 🗆 Yes 2 🔀 No	
	rith th	la l			OCK COURT	,		10f. Zip Co				10g. Citizen o		itry'?	
	eath v	Funeral Director	11. Marital Status	AS CKADD	12. Was Decedent	Ever in U.S	S. 13. V		of Hispanic (Origin? (Spe	cify Yes or No- Rican, etc.)	14. R	A ace - Americ	can Indian,	
36	fter de , or it amine	þ	1 Never Marrie		Armed Forces 1 X Yes 2 If Yes, Give	? ☐ No	1		Cuban, Mexic] No <i>Speci</i>		Rican, etc.)		lack, White,	etc.	
ĕ	ours a atural	Completed	3 Widowed 4	15. Decedent's E	Year or Dates.				,	ry.		Speci	1W	HITE	
715	72 h	lg I		ify only highest gr	ade completed)	. 5 .)	(Give k	ent's Usual O ind of work d) NOT use ret	one durina m	ost of worki	ng	16b. Kind of	Business/In	dustry	
32	filed within 72 hours after death with the Maryland al Hygiene. d other than "natural", or items 23a or 28a-f sho went, <u>the Medical Examiner must be notified at</u>		Elementary/Secor	ndary (U-12)	College (1-4 or 4	(5+)	BUYER	AND ME	RCHAND	ISE M	ANAGER	DEPA	RTMENT	T STORES	
EHM)	ould be filed within 72 hours after death with the Maryland d Mental Hygiene. marked other than "natural", or items 23a or 28a-f show matic event, the Medical Examiner must be notified at	To Be	17. Father's Name (F	irst, Middle, Last)					18. Mc	ther's Name	e (First, Middle,	Maiden Surna	me)		
3a - E	should be file or and Mental H or is marked or raumatic eve	-	LEWIS		СОНЕ	N				LLIAN				HENKIN	
ZW	shr han 7 is trau	li	19a. Informant's Nar	COHEN/W	, ,		1				Route Numbe			•	
COHEN more, Ma	f Health if Health other tra		20a. Method of Dispo	osition		20b. F	Place of Dispos	sition (Name o	of		URT, BA	20c. Location		21208 own, State	
	Page 1 ment of I ant: If it		1 X Burial 2 ☐ 4 ☐ Donation	☐ Cremation 3 ☐ 5 ☐ Other (Speci	Removal from Stat	e BET	emetery, crem 'H EL M			02/0	9/2012	RAND	ALLSTO	OWN, MD	
じのHEN, EHUD Baltimore, Maryland 21215-0036	permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other 1 once.		21. Sigh Jur of Fun				22.	Name and A	ddress of Fac	ility SOL	LEVINS	SON & B	ROS.,	INC.	
	TD = 40		23a Part 1 Enter th	ide y	uger	ad the deat					ROAD, F		LLE, N		
	Physician/		23a. Part 1. Enter th shock, or heart Immediate Cause (F					_						Approximate Interval Between Onset and Death	
	Medical		disease or condition resulting in death)		a. A cute Due to (or as			Infab	CHOU	(N	STEMI)	-	1 day	
-	Examiner		Sequentially list con	ditions	h .		,								
	sit q	nine	cause. Enter Under	misdiate ying	Due to (or as	s a consequ	ience of								
200	ecute and Il-trans	Examiner	Cause (Disease or in that initiated events resulting in death) La		c. Due to (or as	s a consequ	lence of):								
V	cate be executed physician and s the burial-transit	edical			l d										
8760	certificate nding phy: use as the	Med	IF FEMALE:												
Box 68	th cert tendir or use	ian/	23b. Was decedent p		23c. If yes, outcome 1 Live Birth	2 Feta	ıl death 3 🗌	Ectopic preg					Date of delive		
	requires that the death certifical been signed by the attending p should be detached for use as	Physician/M	1 Yes 2 U9 Unknown		4 ☐ Pregnant 9 ☐ Unknown		death 5 ∟	Other (special	fy)				/onth	Day Year	
P.O.	requires that the been signed by the should be detach	by Pr	Part II. Other signific	cant conditions c	ontributing to death	but not res	ulting in the ur	nderlying caus	se given in Pa	rt I.	23e. Did to	obacco use co	ntribute to th	ne cause of death?	
ds,	quires en sign	ed b	Hyperlip	pemia							1 🗆	Yes 2 No	3 🗌 Prol	bably 4 🗆 Unknown	
cor	aw rec as bee	Completed									24a. Was		prior to co	psy findings available mpletion of cause of	
Re	The l							A			perfo	2 No	death?	2 🗖 No	
ita	sician certifi irector	m	25. Was case referred examiner? 1 Yes 2		Hospital:	F			6. Place of D						
of V	y Physer this eral di	e: To	27. Manner of Death		28a. Date of in	iury	ER/Outpatient 28b. Time of	28c.	4 □_ Injury at		me 5 🗌 Resid 28d. Describe h)	
on	ending ath. vr. Afte he fun	ficat	1 Natural 2 Accident	5 Pending Investigation		ay, Year)	injury		work? 1 🗌 Yes 2						
Division of Vital Records, P.O.	or Atte	Certificate:	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could not be determined	28e. Place of In	jury - At ho tc. <i>(Specify</i>		et, factory, of	fice		28f. Location (S City or Tow		ber or Rural	Route Number,	
D	spital ours a ours a leral C		29a. Certifier 1 [Certifying Phy	sician: To the best of	of my knowl	edge death o	ccurred at the	time date a	nd place ar	nd due to the ca	ause(s) and ma	nner as stat	ed	
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has to completely filled in by the funeral director, page 2 or possible to the funeral director, page 2 or possible to the funeral director.	Medical	(Check 2 [only one) 3 [Medical Exam	iner: On the basis of	examination	n and/or investi	gation, in my o	opinion, death	occurred at	the time, date a	ind place, and c	due to the car	use(s) and manner stated.	
	Vith To th		29b. Signature and title of certifier 29c. License number 29d. Date signer												
				our	1	<u></u>			ES - 0	00		Februc	IRY 8	3,7012	
-	10		30. Name and addres	ss of person who			23a) (Type, Pr		altimo	re					
	Stat		31. Date filed (Month,	Day, Year)	32. Regist		ure far								
	Registra	ar	FEI	B 1 3 201	Lenna	1 p.	gar								

Registrar DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year)

Box 68760

P.O.

Records,

of Vital

Division

D.O. 688-C Poole Rd. Westminster

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND #198 PER ANA BD C2/13/2012 JH.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death FEBRUAL Physician/ Marjorit 226 Dillon 2012 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** ofton Rehabilitation (art And 4nnc 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** 1 □ M 2 😿 F Months Days Hours Min. (Month, Day, Year July 10, 1 Country) Virginia 84 577-32-5765 Director Usual Residence of Decedent or 28a-f show notified at 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location filed within 72 hours after death with the Maryland Director 1 Yes 2 No Gambrills MD Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō ms 23a or must be r Funeral IISA 21054 2628 April Dawn Way 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, "natural", or item ledical Examiner n 11. Marital Status Black, White, etc. þ 1 Never Married 2 XMarried Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 X No Specify: Specify: Completed 3 Widowed 4 Divorced permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) own home 0 housewife Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Agatha Karr Otto Parkerson 19a. Informant's Name/Relationship (Type, Print) 19b. MBILGOdr**WOODLAND**/m**IVANE**/mI ROCHESARIAKE/MD to 20732 Dawn Way; Chesapeake Beach, MD 20732 Garland Lee Dillon - husband Department of Health Important: If item 27 any injury or other to once. 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Removal from State 4 □ Donation 5 ☒ Other (Specify) in state Signature Funeral Service Licens 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore St; Baltimore, MD 21201 Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, a heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final onyestive Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Arten Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Examir To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit meuitus that initiated events Due to (or as a consequence of resulting in death) Last Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Year Month Day Pregnant at time of death 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No 2 No Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital 2 🗆 No 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 잍 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred injury 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State, Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated in Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) MOWERY GIY BC R146251 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EILN'dge Maryland 21075

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dolores 2012^{Year} Rose Dunaway Day Physician/ Feb. 10:50 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death FutureCare Northpoint Nursing Home Baltimore Co. Baltimore Co. 8. Date of Birth (Month, Day, Year) June 15,1922 Social Security Number If Under 1 Year | If Under 24 Hrs 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 1 □ M 2XXF Hours Mary land Director 214-14-0160 89 Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10h. County 10a. State 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director MD Baltimore Dundalk 1 ☐ Yes 2 🖁 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a Funeral 1602 Evergreen Drive United States 21222 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14 Race - American Indian. Black, White, etc. 1 Never Married 2 Married Completed by 1 Yes If Yes, Give 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 🗌 Widowed 4 🗌 Divorced White Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 12 Years Housewife Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ William Huber Rosalie Staab permit. Page 1 and 2 shoung Department of Health and Important: If item 27 is many injury or other traums 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 1602 Evergreen Drive Dundalk, Maryland Mr. Archie L. Dunaway (Husband) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place Holly Hill Mem. Gdns 2/8/2012 Middle River, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Severe Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examiner Due to jor as a consequence of cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed within 24 hours after death.

To the Funeral Director: After this certificate I 1 Yes 2 W 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes Other: 2 No 잍 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State Medical 29a Certifier t Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar Tigar.

Shah

FEB

ととなると

. M.D.

8813

3 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Walthown

D 69540

words and swite 204 Parkville MD

02/06

2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ February Mary Margaree England 2012ª 8:10P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Brighton Gardens Columbia Howard Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Hours Min Dave 308-07-8053 **Director** 1 M 2X F 92 January 3,1920 Indiana Usual Residence of Decedent 28a-f shov must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Howard Laurel 1 Yes 2 X No 10e. Street and Number ō 10f, Zip Code 10g. Citizen of What Country? items 23a Funeral 11325 Bishops Gate Lane 20723 U.S.A. 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. ö q 1 Never Married 2 Married 1 Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White "natural", Specify: Completed 3XX Widowed 4 □ Divorced Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. College (1-4 or 5+) Elementary/Secondary (0-12) the Monroe County School System Teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Clayton Roy Powlen Fay Alice Jones Jee 1 and 2 shr Jepartment of Health and Important: If item 27 is many injury or other 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11325 Bishops Gate Lane Laurel, Maryland 20723 William L. England (Son) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Rosehill Cemetery 2-18-2012 Bloomington, Indiana 4 Donation 5 Other (Specify) 21. Signature of Funcal Service Licensee Witzke Funeral Homes, Inc. 22. Name and Address of Facility 5555 Twin Knolls Road Columbia, Maryland 21045 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Years shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ Breast Cancer disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to him column cause. Enter Underlying Cause (Disease or injury Examine bus to for sels consequence of the burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of): physician Completed by Physician/Medical as be detached for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 X No 5 Other (specify) Month Day Pregnant at time of death Year Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page performed? Yes 2 No this certificate 2 🗆 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 1 Yes 2 🗶 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 X Other (Specify)

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 after death. Director: After 24 hours

မြ

Certificate:

Medical

funeral director, the filled in by

Manner of Death 1 X Natural 5 Pending ☐ Accident

Investigation Suicide 6 Could not be 4 Homicide determined

🕱 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier

29c. License number

28c. Injury at

work? 1 🗌 Yes

2 🗌 No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

D56531 2-09-2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Harry Li 8600 Snowden River Parkway #301 Columbia, MD 21045

31. Date filed (Month, Day, Year) State Registrar

29a. Certifier

32. Registrar's Signature

28a. Date of injury

(Month, Day, Year)

DHMH 17 Rev 06-2011

X

within 2

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ February 20°1°2 12:55 PM Hortense Ellis Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Casey House Rockville 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours Jan 14, Year 1917 Minnesota **Director** 477-03-8160 95 1 🗆 M 2 🛣 Usual Residence of Decedent 28a-f shov 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County with the Maryland notified at Director 1 Yes 2 XNo Rockville MD Montgomery 10e, Street and Number 10f. Zip Code ò 10g. Citizen of What Country? ıral", or items 23a or Examiner must be ı Funeral USA 20853 18110 Cashell Rd. within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 white If Yes, Give Year or Dates 1 ☐ Yes 2 💢 No Specify: "natural", 3 Widowed 4 Divorced Completed the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industryunk (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 72 tal Hygiene. Elementary/Secondary (0-12) College (14 or 5+) secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental ဂ္ဂ Isabelle Toby traumatic James George Hafiz ge 1 and 2 should be nt of Health and Men :: If item 27 is marke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1305 Riverside Dr; Fullerton, CA 92831 Lorraine Mahr - sister other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Department or Important: If any injury or once, ō 4 □ Donation 5 🛛 Other (Specify) in state Signat /e of mod Service Lio nese Rona Waste 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore St; Baltimore, MD 21201 Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, on tear failure. List only one cause on each line. Onset and Death Immediate Cause (Final left thalamic and cerebellar infarction Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of **Examiner** atrial fibrillation Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) ipital or Attending Physician: The law requires that the death certificate be executed ours after death.

eral Director; After this certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 XNo Month Day Year Pregnant at time of death Unknown g 🔲 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2X No 25. Was case referred to medical 26. Place of Death (Check only one) Be 1 ☐ Yes 2 X No ဂ 1 Inpatient 2 I ER/Outpatient 3 DOA 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours To the Funeral L To the Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0060634 2/5/2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bindu Joseph CASEY HOUSE ROCKVILLE, MARYLAND 31. Date filed (Month, Day, Year, State FEB Registrar

			Please	Type or Prin								ible.	
		For State Registrar		State of Ma	aryland		artment of I <i>rtificate of</i>		nd Ment		ene _{3. No.} 2 (112	03925
Physicia		1. Decedent's Nam	e <i>(Fir</i> st, <i>Middle, L</i> Marcelle							ate of Death lonth ruary	^{Day} 2	0 1º2º	3. Time of Death 5:15 A M
/Medic Examin		4a. Facility Name (i	If not institution, g	ive street and number)	itati	on	4b. City, Town, o	or Location of D			4c. County	y of Deatl	
Funeral		5. Social Security N				ast birthday,		If Under 24		ate of Birth Month, Day,		9. Birti	hplace (State or Foreign untry) orth Carolina
Director		245-38 Usual Residence of		1 X M 2 □ F	84	Yrs.			Nov	7 9, 19	927	No	orth Carolina
aryiand show	o.	10a. State MD	10b. County	gomery		Town or L	Spring						10d. Inside City Limits 1 □ Yes 2 X No
with the N 3a or 28a-f	Funeral Director	10e. Street and Nu	_		, 01		10f. Zip Code 20902	2		100	g. Citizen of USA	What Co	untry?
urs after death al", or items 23 Examiner mus	þ	11. Marital Status	ied 2. Married	12. Was Decedent Armed Forces?		S. 13.	Was Decedent of If Yes, specify Cut	oan, Mexican, P	n? (Specify \ Puerto Ricar	ı, etc.)	Special Special	ick, White fy: b1a	ick
(Specify only highest grade completed) College (1-4or 5+)											iusiness/	Industry UNK	
and 2 sho ealth and I n 27 Is ma er trauma	19a. Informant's Name/Relationship (Type. Print) Sylvia Thomas - niece 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, September 2018) 4616 Erin St; Winstom-Salem, NC 271											105	
Pages 1 ment of H ant: If iter ury or oth		20a. Method of Dis 1 ☐ Burial 2 4 ☐ Donation		□Removal from State	20b. P	emetery, c <i>r</i> e	osition (Name of matory or other pla		Date		Oc. Location		Town, State
permit Depart Import any in		21. Signature of Fr	Ronald S	Wade bi	ecto:		2. Name and Addr				-		21201
Physician		shock, or hea Immediate Cause disease or condition	art failure. List on (Final on	implications that caused by one cause on each life a.	ne		nter the mode of dy				st,		Approximate Interval Between Onset and Death
/Medical Examiner		resulting in death)		Due to (or as									
executed n and ial-transit	Examiner	Sequentially list co if any, leading to in cause. Enter Unde Cause (Disease on that initiated event resulting in death)	\$	Due to (or as									
cate be ex ohysician a		resulting in deathy	Last	Due to (or as	a consequ	Lence oi):							
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was deceder in the past 12 1 □ Yes 2 9 □ Unknown	2 months? □ No	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal	I death 3	☐ Ectopic pregnar ☐ Other <i>(specify)</i>	псу				ate of de Ionth	livery Day Year
quires that	by	Part II. Other signi	ificant condition	s contributing to death b	NSI	ulting in the	underlying cause g	iven in Part I.	_	23e. Did toba 1 ∐ Yes			o the cause of death? robably 4 Unknown
: The law recate has being page 2 sho	Completed	**								24a. Was an autopsy perform 1 □ Yes 2	ed?	prior to death?	utopsy findings available completion of cause of s 2 □ No
ysiclan is certifi director	o Be	25. Was case refe examiner? 1 ☐ Yes 2 ☐		Hospital: 1 ☐ Inpati	ent 2 🗆	ER/Outpation	ent 3 DOA	thor:		eck only one		ther (Spe	ecify)
nding Ph ath. r: After th e funeral	ation: T	27. Manner of Dea 1 ☑ Natural 2 ☑ Accident	th 5 ☐ Pending investigat	28a. Date of Inju (Month, Da	iry ay, Yea <i>r</i>)	28b. Time Injury	We	uryat ork? ⊒Yes 2 ⊒No		Describe how	w injury occu	rred	
tal or Atters after dea	Certification: To	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could no determine	28e. Place of In building, el	ury - At ho c. <i>(Specif</i>	ome, farm, s	treet, factory, office)	28f. l	ocation (Stre City or Town,	eet and Nun State)	nber or R	ural Route Number,
e Hospi n 24 hou ne Funer pletely fill	Medical	29a. Certifier (Check only one)	1 Certifying 2 Medical Ex	Physician: To the best caminer: On the basis of and manner st	of examina	wledge, dea tion and/or	ath occurred at the investigation, in my	time, date and opinion, death	place, and occurred a	due to the ca t the time, da	ause(s) and rate and place	nanner a	as stated. e to the cause(s)
To th within To th	Me	29b. Signature and	d file of certifier	2	M	D.	29c. Licer	se number 2	013	29	od. Date sign	ed (Men	th, Day, Year)
		30. Name and add	itul	no completed cause of o	death (Iten	23a) (Type	, Print) V90let	- dri	re !	Ellica	st a	ty	21042
Sta Registr		31. Date filed (Mo	FEB 13	2012 January	rar's Signa	tue de	artel		,)	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month February Physician/ Friedel 2012 Margaret Jane 5:30 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Essex Riverview Care Center If Under 1 Year | If Under 24 Hrs. Funeral Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Months Hours 04/2174919 Maryland Director 92 217 07 1742 Usual Residence of Decedent show be filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits Director must be notified 1 🗆 Yes 2 🗀 No Essex Maryland Baltimore 10e. Street and Number 0 10f. Zip Code 10g. Citizen of What Country? 23a Funeral United States 21221 620 Maryland Avenue ral", or items ? Examiner mus Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Bace - American Indian Armed Forces Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: white 3 ☑ Widowed 4 ☐ Divorced Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) d Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker 10 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Alice Ε. Sheperd Albert Steele R. Page 1 and 2 should and l 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 316 Margaret Avenue Essex Maryland 21221 Health sem 27 i Martin Friedel Department of Health Important: If item 27 any injury or other to Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory Inc 02/10/2012 |Baltimore Maryland atore of Funeral Service License 22. Name and Address of Facility Bruzdzinski Funeral Home PA 1407 Old Eastern Avenue Essex Maryland 21221 nter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Ph. sician ONE Cardisvasteld Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 Yes 2 No Month Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate Yes 2 No within 24 hours after death.

To the Funeral Director, After this certifica completed filled in by the funeral director, to 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending 1 ☐ Yes 2 ☐ No Accident Suicide Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide City or Town, State) Medical 29a. Certifier Lecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Description: Description of the basis of examination and/or investigation, In my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month. Dav. Year)

Registrar

State

31. Date filed (Month,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 2012 12:46 am Gerard J. Ferri. Sr. /Medical 4a. Facility Name (If not institution, give street and number) Town, or Location of Death 4c. County of Death Examiner Franklin Square Baltimor HOS 0 e 8. Date of Birth (Month, Day Year) 04-29-1922 If Unde **Funeral** Days Months Hours 214-14-3090 89 Maryland **Director** Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinating that the model and the model and the model. 1 ☐ Yes 2 No Baltimore Nottingham Director Maryland 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21236 USA 4409 Darleigh Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 XYes 2 No 14. Race - American Indian 11. Marital Status Black, White, etc. 1 □XYes 2 □ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: WII 2 3 Nidowed 4 Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life, DO NOT use retired)
Ship Welder o. Kind of Business/Industry Coast Guard ip Yard 15. Decedent's Education (Specify only highest grade completed) US CO Ship Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) Domenica Zamponi Dominic Ferri ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, Maryland 21236 4409 Darleigh Road Mrs. Celeste Smith - Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pages 1 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donatjen 5 ☒ Other (Specify) Entonoment Gardens of Faith Cemetery Baltimore, Maryland 02-15-2012 21. Signature of Funeral Savice Ligensee 22. Name and Address of Facility 5305 Harford Road Leonard J. Ruck, Inc. Baltimore, Maryland 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Coronar disease or condition resulting in death) Due to (or as a consequence of): /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760, attending physician certificate be Physician/Medical as the IF FEMALE use 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Live birth 2 Fetal death 3 Ectopic pregnancy for Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) P.O. detached 1 ☐ Yes 2 ☐ No the 9 Unknown signed by t. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performe this certificate 1 ☐ Yes 1 □Yes 2 No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To : After thi 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division To the Hospital or Attending 1 Natural 5 Pending investigation Within 24 hours arter community to the Funeral Director: Afternated filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 1/2001

State

erri, Genaro

WUNSTILL

Name and address of person who completed cause of death (Item 23a) (Type, Print)

D0063327

9000 Franklin Square Or, Balto, MO 21237

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend 5, per fh, 8924 2-1/-12 sm
State of Maryland / Department of Health and Mental Hygiene 2

1- State Amend Item 23a per dr., g926, 04/25/2012dhb
Reg. No.

Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 2 **Physician** 15 2010 Robert Eugene Grimes /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner (ente Kosdale ospitai Quare HIMORE If Under 1 Year | If Under 24 Hrs. Security Number -24-0563 Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 📈 2 🗆 F Months Days Hours Min Yrs 83 4/5/1928 Director Pennsylvania Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits show ms 23a or 28a-f shov Director 1 ☐ Yes 2X No Maryland Baltimore Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 904 N. Woodward Drive 21221 Funeral U. S. A. items. 12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☐ Yo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. traumatic event, the Medical Examiner 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ō 1 □Yes 2 □XNo Specify <u>م</u> 3 ☐ Widowed 4 ☐ Divorced Specify: "natural" White Completed 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Health and Mental Hygiene. em 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) 10 Carpenter Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be should be ပ Stanton Grimes Elsie Bryant 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s 904 N. Woodward Drive Essex, Maryland 21221
e of Disposition (Name of Date 20c. Location - City or Town, State Ellen Elain Grimes (Wife) other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Pages 1 Department of Important: If it any injury or o 1 Burial 2 □ Cremation 3 □ Removal from State 2/15 4 ☐ Donation 5 ☐ Other (Specify) Bel Air Memorial Gardens Bel Air, Maryland permit. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bruzdzinski Funeral Hom 1407 Old Fastern Avenue Home PA Essex, Maryland 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** iRatore disease or condition resulting in death) /Medical Due to (or as a consequence of). Examiner Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine law requires that the death certificate be executed Abestosis and burial-tran resulting in death) Last Due to (or as a consequence of). Box 68760, physician Physician/Medical the as attending IF FEMALE: nse s 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy į in the past 12 months? Month Year Dav 5 ☐ Other (specify) P.0. 1 □Yes 2 □ No. the detached 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy The certificate 2 No of Vital 1 □Yes 2 No 1 □Yes Physician; director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient this Certification: To 2 ER/Outpatient 3 DOA After this funeral d 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division Hospital or Attending 1 Natural (Month, Day, Year) 5 Pending the Funeral Director: Aft investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medical (Check only one) the 5 29b. Signature and title of certifier KOUSAYA ARUNAGIR I 29c. License number 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 9000 Ma. ousal HRUNAGIR 31. Date filed (Man EB 1 2 State legistrar's Signature Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible lnk. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month 1:25 AM **Physician** GOGEL 2013 WILLIIAM EBAUARY /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner N/A Johns Hopkins Bayview Medical Center Baltimore 8. Date of Birth
Month, Day, Year)
June 2, 1931 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 1 ÅM 2 □ F 7. Age (In vrs. last birthday) **Funeral** Days Hours Min. New Jersev 213-28-9961 80 Director Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland leath and Mental Hygiene. 10d. Inside City Limits 10a State 10h County 10c. City. Town or Location or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Director MD Baltimore Dundalk 10e. Street and Number 10f, Zip-Code 10g. Citizen of What Country? 21222 United States 1700 Pinewood Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☑ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: \$ White 3 Widowed 4 Divorced Year or Dates: Korean Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) other than Religion 12 Years Pastor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Dorothy Borcher is marked David Welby Miller ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 a Department of Health at Important: If Item 27 is any Injury or other trau once. Mrs. Helen Gogel (Wife) 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Meadowridge Mem. Park 2/10/2012 Elkridge, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22 Name and Address of Familia Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland Part 1. Enter the disease of complications that caused the shock, or heart failure last only one cause on each line. complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death immediate Cause (Final HYPERTENSIVE ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE _Physician resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) attending physician and I for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 2 No the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 4 Unknown 1 🗌 Yes 2 No 3 Probably Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? 2 2 🗌 No certificate or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 1 Yes 2 N/6 2 CR/Outpatient 3 DOA 5 Residence 6 Other (Specify) မ this 28c. Injury at Work? 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: Injury 5 Pendina 1 🗌 Yes 2 □ No investigation neral Director: A 2 Accident 3 Suicide 6 Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide after the Hospital within 24 hours a 29a. Certifier (check only 1 [Decritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D23540 2019 511 30. Name and address of perec who completed cause of death (Item 23a) (Type, Print) 4940 Eastern Avenue, Baltimore, MD, 21224 MI 400H Day, Year) 32. Registrar's Signature State FEB Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death FEBRUAGE Day C Physician/ 12:35 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death altimor Cente VSING 7. Age (In yrs. last birthday) **Funeral** 6 Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 220-24-9428 1 M 2 X F 97 Ju^{(Month}, 28^v, Year) 914 Mary Tand Director Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10a, State 10c. City, Town or Location 10d, Inside City Limits Director MD Carrol1 Sykesville 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6009 Snowdens Run Rd. 21784 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Completed by 1 Never Married 2 Married 1 Yes Baltimore, Maryland 21215-0036 should be filed within 72 hours was and Mental Hygiene. 1 ☐ Yes 2 K No Specify. Specify: White 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Sales Credit Office Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Selby Do11 Mary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s f Health item 27 6009 Snowdens Run Rd., Sykesville, MD 21784 Frank J. Griffin, Jr. (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite Date 1 Durial 2 Cremation 3 Removal from State Loudon Park Cemetery 2/11/12 Baltimore, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Loudon Park Funeral Home any 3620 Wilkens Ave., Baltimore, MD 21229 23a. Part 1 First the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Pregnant at time of death Month Day Year P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 No 3 ☐ Probably 4 ☐ Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an OW autopsy perform death? 2 No Yes Division of Vital 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes 2 X No Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 Residence 6 Other (Specify) 27, Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Natural 28c. Injury at 28d. Describe how injury occurred work? 5 Pending Investigation Could not be 2 🗌 No Accident 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

wn

31. Date filed (Month, Day, Year)

0

enson

Hvenue

Physician/ Medical **Examiner Funeral** Director 28a-f shov must be notified at 0 23a "natural", or iter edical Examiner injury or other traumatic event, the Medical Mental Hygiene. larked other than . Page 1 and 2 st tment of Health a tant; If item 27 is

12. Was Decedent Ever in U.S. Armed Forces? Completed by 1 Never Married 2 Married 2 XNo 1 ☐ Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: 3 ¥ Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) HOMEMAKER Be 17. Father's Name (First, Middle, Last) ပ္ ISAAC SCHIMBERG SHEVA 19a. Informant's Name/Relationship (Type, Print) AMY GINSBERG/DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1

Burial 2

Cremation 3

Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Ser Immediate Cause (Final disease or condition Physician/ ementia Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Pregnant at time of death 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ Records, Completed Director; After this certificate Division of Vital completed filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) 1 ☐ Yes 2 2 1√10 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at To the Hospital or Attending 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide within 24 hours a To the Funeral C Medical 29a. Certifier (Check 3 [29b. Signat<mark>/</mark>re and title of certifi 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Sig State Registrar

State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 8 FEBRUARY 2012 3:00 A LENORE GINSBERG 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death ARDEN COURTS BALTIMORE BALTIMORE Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs 8. Date of Birth Birthplace (State or Foreign Country) 1 □ M 2X F Hours (Month 124/1918 223-03-3443 93 MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD N/A 1 💢 Yes 2 🗌 No BALTIMORE 10e. Street and Number 10g. Citizen of What Country? Funeral 6350 RED CEDAR PLACE, UNIT 406 21209 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Black, White, etc. WHITE 16b. Kind of Business Industry OWN HOME 18. Mother's Name (First, Middle, Maiden Surname) UNKNOWN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6350 RED CEDAR PLACE, #406, BALTIMORE, MD 20c. Location - City or Town, State HILLTOP SERVICE CORP: 02/09/2012 TOWSON, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or cour lications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only ne cause on each line. Interval Between Onset and Death 10a1 23d. Date of delivery Month Year 23e. Did tobacco use contribute to the cause of death? 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe death? 1 🗌 Yes Yes 4 Nursing Home 5 Residence 6 Other (Spec 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Charles St Suite 9105, Tousan mo

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** /Medical 4b. City, Town, or Location of Death Examiner Johns Hopkins Bayview Medical Center Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Min. | May 16, 1941 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 XM 2 □ F 218-36-5375 70 Maryland Director Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland teatith and Mental Hygiene. m 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County the Medical Examiner must be notified at 1X Yes 2 ☐ No Directo Baltimore City Md. 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code 638 South Streeper Street 21224 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. ty⊒yes 2[If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 TNo ۾ Specify: 3 Widowed 4 Divorced White Completed 16b, Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) <u>Chemical Company</u> 12th <u>Chemical Engineer</u> <u>2yrs</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Michael A. Gull, Sr. Margaret H. Brown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If Item 27 Is any Injury or other trau 638 South Streeper Street Baltimore, Md21224 Dolores Gull / Wife 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of MO Saftetery, crematory or other place) February 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11, 2012Baltimore, Maryland Holy Redeemer Cem M00933 22. Name and Address of Facility Kaczorowski Funeral Home, 21. Signature of Funeral Service Licensee 1201 Dundalk Avenue Baltimore, Md.21222 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine The law requires that the death certificate be executed completely filled in by the funeral director, page 2 should be detached for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician Physician/Medical IF FEMALE: 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Tetal death 3 Ectopic pregnancy in the past 12 months? Month Year Pregnant at time of death
Unknown 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? \$ 2 No 3 Probably 4 Unknown 1 es Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 \sum Nursing Home 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 ☐ Other (Specify) ၉ 28a. Date of Injury 27. Manner of Death
1 Natural
2 Accident 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 🗌 Yes 2 🗌 No 3 Suicide 6 Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide City or Town, State)

Box 68760. Division of Vital Records, P.O. 24 hours after death. Funeral Director: After the Hospital or Attending within 2

> State Registrar

Medical

29a. Certifier

(check only

29b. Signature and title of certifier

DHMH 17 Rev 1/2001

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

4940 Eastern Avenue, Baltimore, MD, 21224

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ James E. Hunt FEBRUAR 6,2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner AINT JOSEPH MEDICAL CENTER 10WSON 8. Date of Birth (Month, Day, Year) 1 - 9 - 1 9 4 9 If Under 1 Year If Under 24 Hrs Birthplace (State or Foreign Country) 6. Sex **Funeral** 217-54-1523 63 Director Maryland Usual Residence of Decedent ul Hygiene. I other than "natural", or items 23a or 28a-f show vent, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Baltimore Lutherville 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8524 London Bridge Way 21093 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Armed Forces? Black, White, etc. by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Army 1 Yes 2 No Specify: If Yes, Give Year or Dates White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Archbishop Borders permit. Page 1 and 2 should be filed with Department of Health and Mental Hygier Important: If item 27 is marked other t. any injury or other traumatic event, tile Once. Teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Edward Hunt Ella Mae Westerfield 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Delores M. McMannis - Sistee 2672 Denmark Rd. Columbus, Ohio 43232 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 2/16/2012 Crownsville, MD Crownsville 4 Donation 5 Other (Specify) 22. Name and Address of Facility Joseph N. Zannino Jr. FH 263 S. Conkling St. Baltimore, MD 21224 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, shock, or heart failure. Ist or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Interval Between Onset and Death HOUR SYSTOLE Immediate Cause (Final Physician/ disease or condition resulting in death) Medical **Examiner** YOUARDIAL INFARCTION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Box 3 ☐ Ectopic pregnancy5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No Pregnant at time of death Month Day Year 1 ☐ Yes ∠ ☐ 9 ☐ Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ARTERY Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No has autopsy performed' Yes 2 No the Hospital or Attending Physician: hin 24 hours after death. of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 No ပ 1 Inpatient 2 K ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) completely filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Division Accident Investigation 24 hours after deat Funeral Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 🜠 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F only one) 29b. Signature and title of cortifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CZARNECKI, M.D.
Year) 32. Registrar's Signature DRIVE TOWSON MARYLAND 21204 7601 31. Date filed (Month, Day, Year) Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ February 1015 Barbara A. Hackert 2012 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death Widomico Salisburg Rehabilitation & Narsing City If Under 24 Hrs. 8. Date of Birth (Month, Day, March 19 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** ^{Year)}1925 1 □ M 2 🛛 F Yrs. New York Director 86 050-22-0227 Usual Residence of Decedent 28a-f show 10a. State 10b. County e filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director or other traumatic event, the Medical Examiner must be notified 1 🗆 Yes 2 🎽 No Wicomico Salisbury MD 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code 23a 21801 Funeral 221 North Blvd. "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 😾 No Specify: white Specify. Completed 3 Divorced 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) own home homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Jessica May Pickett John J. Furia 19a. Informant's Name/Relationship (Type, Print) Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $221\ North\ Blvd;\ Salisbury,\ MD\ 21801$ Raymond Hackert - husband 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date per it. Page 1
Decartment of I
Important: If it
any injury or or
once. ■ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place, X 4 Donation 5 Other (Specify) 22. Name and Address of Facility State Anatomy Board 21. Signat F o Funeral Service License 21201 655 W. Baltimore St; Baltimore, MD 23a. Part 1 Printer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician Medical Examiner sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): the attending physician and hed for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy 3 in the past 12 months?
1 ☐ Yes 2 🗷 No Month Day Year filled in by the funeral director, page 2 should be detached 9 Unknown 9 Unknown significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 🌠 No 24a. Was an nas autopsy performed? Yes 2 No the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 🗷 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Date of injury (Month, Day, Year) 28b. Time of 27 Manner of Death 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 Yes 2 No Accident Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined hours after within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certific 29d. Date signed (Month. Day, Year) 29505 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GREGORIO M. BELLOSO 5302 CHINABERRY DR., SALISBURY, MD 32. Registrar's Sign

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #9, 11, 12, 15, 17, 18, 19b, Per, ANA, BD, G924, 2/15/2012, JH. State of Maryland, Department of Health and Mental Hyglene. State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 0354 February Medical 4a. Facility Name (if not institution, give street and number **Examiner** Town, or Location of Death 4c. County of Death HOPKINS HIMOre 9. Birthplace (State or Foreign Country) unly Marland 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Director 75 216-66-6849 1 🛛 M 2 □ F June 30, 28a-f show at 10a. State 10b. County 10c. City, Town or Location death with the Maryland 10d. Inside City Limits Director must be notified MD Baltimore 1X Yes 2 □ No 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 402 S. Bond St. 21231 USA ı "natural", or item edical Examiner m 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian. Armed Forces? Yes 2 No Yes, specify Cuban, Mexican, Puerto Rican, etc. Black White etc Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 72 hours after 1 Yes 2 No Specify white If Yes Give XX Widowed 4 Divorced Year or Dates is marked other than "natur aumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation unk (Give kind of work done during most of working 16b. Kind of Business/Industry unk Department of Health and Mental Hygiene. Important: If flem 27 is marked other than " any injury or other traumon: life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) unk Be 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) unk-ပ Ceci1 Hacker Simmons Georgia 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ${
m unk}$ David Hacker - brother 601 S. Macon Street Baltimore,MD 21224 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 🛛 Other (Specify) in state Euneral Soni e Licens Lional I S. 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore St; Baltimore, MD 21201 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest represents a cardiac or respiratory arrest represents the control of the cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Squamous all disease or condition carcinona Atrion E Medical resulting in death) s a consequence of) Examiner Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or injury Querto El riga a conservience di the Hospital or Attending Physician: The law requires that the death certificate be executed and the burial-tra that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ eral Director: After this certificate has been signed by the atter filled in by the funeral director, page 2 should be detached for in the past 12 months?

1 Yes 2 No Month Pregnant at time of death Day Year 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 🖳 Yes 2 □ No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an death? perform performed? Yes 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) 2 🛮 No Hospital Other: Certificate: To 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 5 Pending Natural 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a To the Funeral I Medical 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Setting Nysican to the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. RES-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mitchel 31. Date filed (Month, Day, Year) State Registrar FEB 1

12-01009 Margo Hughes

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2012 03936 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) Physician/ 2. Date of Death Month Day February 3, 2012 Medical Examiner 0845 hrs Margo Hughes 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death Franklin Square Hospital Center Rosedale **Baltimore County** 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Director Months Days Hours 213-70-5133 Country) MA 2 X F 47 March 21, 1964 Usual Residence of Decedent 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 X No mit. Pages I and 2 should be filed within 72 hours after death with the Maryland partment of Health and Mental Hygiene. portant: If item 27 is marked other than "natural", or items 23a or 28a-f sho iry or other traumatic event, the Medical Examiner must be norified at non-MD Baltimore Roseda1e Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country 4994 Brightleaf Ct. 21237 USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Armed Forces? White, etc. 1 Never Married 2 X Married Yes 2 X No 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify: Specify: 2 **Black** 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) paralegal legal 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be William Joseph Gibson <u>Adele Hardy</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Herbert Hughes - husband <u>4994 Brightleaf Ct; Rosedale, MD 21237</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Burial 2 Cremation 3 Removal from State crematory or other place) 4 X Donation 5 Other Specify. 22. Name and Address of Facility State Anatomy Board 21. Si nature of Funeral Service License Director 655 W. Baltimore St; Baltimore, MD 21201 art I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** ure. List only one cause on each line. Retween Onset and Medical Death a Pulmonary Thromboembolism Immediate Cause (Final disease ±xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): Examiner (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and - transi The law requires that the death certificate be executed Sa UNPENDED AMENDED signed by the attending physician 1 be detached for use as the burial Physician/Medi Division of Vital Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth Fetal death 3 Ectopic pregnancy Day Year past 12 months? 2 Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 ✓ Unknown Unknown Part li. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 ✔ Unknown obesity has been si 2 should b 24b. Were autopsy findings available 24a Was an autopsy prior to completion of cause of performed? death? this certificate page ✓ Yes 2 No 1 🗸 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certificompletely filled in by the funeral director, 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient 2 🖊 ER/Outpatient 3 Other Nursing Home 5 Residence 6 Other: DOA 1 V Yes 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury Certification: 1 V Natural Pending 1 Yes 2 No 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) COME O.C.M.E. February 4, 2012 Name and address of person who completed completed Theodore M. King, Jr., MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (Month B 1 3 2012 32. Registrar's Signature State FEB Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Month Year 930 PM Canice Sheridan Hatoff Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death FRANKLIN SQUARE HOSPITAL Rosedal Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Maryland

Month, Day, Year)

December 3, 1939

Maryland Days Hours Min 219-26-5006 **Director** 1 □ M 2 🗓 F 72 28a-f shov ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore Baltimore 1 Yes 2xx No 10e. Street and Numbe 10f. Zip Code 10g, Citizen of What Country? Funeral 1805 Greencastle 21237 Drive USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 Never Married 2 Married Completed by 1 Yes Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: White 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Supervisor Insurance Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George William Seabrease, Jr. Eunice Virginia Eline : Page 1 and 2 should b tment of Health and Mer tant: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anita J. Hatoff / Daughter 1805 Greencastle Drive Baltimore MD 21237 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Gardens of Faith 4 Donation 5 Other (Specify) 2/13/12 Baltimore Maryland 21. Signature of Funeral Service Licensee 22 Name and Address of Facility Leonard J. Ruck, Thc. 5305 Harford Road Baltimore Maryland 21214 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph sician/ Respitory percoubic disease or condition - Medical resulting in death) Due o (or as a consequence of) Examiner P Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed physician and is the burial-trans that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Day Year been signed by the a should be detached 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Fibrillation DISERSE , coronary Artery 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has ral director, page 2 performed' 2 🗌 No Yes 2 No 1 🗌 Yes Be 25. Was case referred to medica 26. Place of Death (Check only one) 1 🗌 Yes Other: ဂ္ 1 Inpatient 2 | ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred eral Director: After filled in by the funer Natural 5 Pending 2 Accident 1 Yes Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \square Homicide determined within 24 hours a

To the Funeral C

completely filled To the Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifiei 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) 181 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 (charil 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 3 2012 Registrar

an 10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Hawkins Jimmy L. 1)00 a M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Joseph Ritchie Hospice Baltimore Social Security Number 8. Date of Birth Sept. 16, If Under 1 Year I If Under 24 Hrs. 7. Age (In yrs. last birthday 9. Birthplace (State or Foreign **Funeral** Days Hours 214-68-2658 MD MD 54 **Director** 1 🛂 M 2 🗆 F Usual Residence of Decedent shov at 10a. State 10c. City, Town or Location death with the Maryland 10d. Inside City Limits Director ems 23a or 28a-f sh r must be notified a 1 Yes 2x No MD Baltimore Gwynn Oak 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21207 USA 1107 Landington Ave. ıral", or items 2 I Examiner mus Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces Black, White, etc. 1 Never Married 2 Married Completed by 1 Yes Maryland 21215-0036 1 Yes 2 No Specify "natural", Specify: Black 3
Widowed 4 Divorced Year or Dates Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natu any injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) Aid Hosp₊ce Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျ Hawkins Gross Leroy Mrnnie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1107 Landington Ave., Gwynn Oak, MD 21207 Pearlene Coleman (Sister) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Loudon Park Cemetery 2/13/12 Baltimore, Ma_yland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Loudon Park Funeral Home 3620 Wilkens Ave., Baltimore, MD 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) the attending physician and thed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Be Completed by Physician/Medical P.O. Box 68760 アガビう IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery To the Funeral Director; After this certificate has been signed by the atter completely filled in by the funeral director, page 2 should be detached for i in the past 12 months?

1 Yes 2 No Month Day Year 1 Yes 2 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director; After this certificate has autopsy performed, death? Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 횬 1 🗌 Yes 2 🛛 No Other: 1 Inpatient 2 ER/Outpatient 3 DDA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending 1 Yes 2 No Investigation 6
Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Physician: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Physician: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bret 140, 71 20 every men 31. Date filed (Month, Day, Year) Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ^{Day} 2012 Year FEBRUARY JOSEPH HAUS 11:00A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE 10 BEAU MONDES COURT REISTERSTOWN Social Security Number 7. Age (In vrs. last birthday If Under 1 Year If Linder 24 Hrs. 8 Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 🕅 M 2 🗆 F 08/12/1945 UZBEKISTAN 66 Yrs. Director 212-58-5841 Jsual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1 ☐ Yes 2 🛣 No MD BALTIMORE REISTERSTOWN 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 10 BEAU MONDES COURT 21136 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, 1 Never Married 2 Married ş 1 ☐ Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify "natural", 3 Divorced Completed WHITE Year or Dates permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical. Decedent's Education 16a. Decedent's Lisual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ TEACHER EDUCATION Be 17. Father's Name (First, Middle, Last) 18, Mother's Name (First, Middle, Maiden Surname) ည BEN-ZION HAUS ALEXANDRA POLISHTOCK 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SARA HAUS / WIFE 10 BEAU MONDES COURT, REISTERSTOWN, MD 21136 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MOSES MONTEFIORE 02/09/2012 BALTIMORE, MD 21. Signature of Funeral Service 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Exami Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): physician a the burial-Physician/Medical Box 68760 attending p as 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) Pregnant at time of death the Unknown 9 Unknown P.O. I signed by the detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law 24 hours after death.

Funeral Director, After this certificate has leted filled in by the funeral director, page 2. autopsy 2 🗌 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: ပ္ 1 🗌 Yes 4 Nursing Home 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at work? 5 Pending Natural 1 Yes 2 No Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check within 2 To the F only one 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signa

State Registrar 30. Name and ad-

FALLS RD, SUITE 20

eath (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day John Charles Isaacs February 09 Medical 2012 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 8118 Poplar Avenue Rosedale Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1**XX**M 2 □ F Hours Min. 04/2371954 217-48-4377 Tennessee Director Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location the Medical Examiner must be notified at 10d. Inside City Limits Director Maryland Baltimore 1 Yes 2XXNo Rosedale 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 8118 Poplar Avenue 21237 U.S.A. 11. Marital Status Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. ò þ 1 Never Married 2 X Married 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 'natural", Completed 3 Divorced White 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Packaging For Lift Operator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F .. Page 1 and 2 should be fill tment of Health and Mental tant: If item 27 is marked or James Clell Isaacs Crystal McCloud 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Teresa Isaacs (Wife) 8118 Poplar Avenue, Baltimore, Maryland 21237 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State injury or 1 Burial 2 X Cremation 3 Removal from State Department o Important: If any injury or Bayview Crematory 4 Donation 5 Other (Specify) 02/10/2012 Baltimore, Maryland 22. Name and Address of Facility Bruzdzinski Funeral Home, P.A. 1407 old Eastern Avenue, Essex, Maryland 21221 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death sheck, or heart failure. List only one cause on each line. ediate Cause (Final Physician/ ease or condition Medical ulting in death) Due to (or as nsequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury Examine Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Cther (specify) in the past 12 months? Month Dav Year Pregnant at time of death 9 Unknown g Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page perform Yes 2 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 2X No မ 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending work?
1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Cheo Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 3 [one) d title 2007128 Name and address of person who completed cause of death (Item 23a) (Type, 77), WWF Shaheem, G791 M. Charles S Baltineous State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ <u>Joseph Ree</u>d Karsner III 2012 Medical 4a. Facility Name (if not institution, give street and number) Town, or Location of Death Examiner 4c. County of Death Oseda. timo If Under 24 Hrs A. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Min. 220-30-2932 77 1 🛣 M 2 🗆 F Director Dec 10. 1934 Marvland 28a-f show 10a State ms 23a or 28a-f sho must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Baltimore Rosedale 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 5356 Millfield Rd. 21237 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ② No If Yes, Give Year or Dates. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. ö Š 1 Never Married 2 X Married 1 ☐ Yes 2 X No Specify. white "natural", Specify: Completed 3 Widowed 4 Divorced permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical Eonce. 16a. Decedent's Usual Occupation UNK (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) unk unk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) unk ည 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5356 Millfield Rd; Rosedale, MD 21237 Anna Karsner - wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 ☐ Other (Specify) 22. Name and Address of Facility State Anatomy Board are Janeral Service License 655 W. Baltimore St; Baltimore, MD 21201 Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ ardiac disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leaving to immediate cause. Enter Underlying Cause (Disease or injury as a consequence on. -transit and that initiated events resulting in death) Last Due to (or as a consequence of) burialphysician as the burial Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Year Pregnant at time of death Day the 9 Unknown Unknown by. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has yes 2 2 🗌 No 1 Yes within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) examiner?

1 Yes Hospital: Other: 2 🗌 No ၉ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 1 Natural injury 5 Pending □ Accident M Investigation Suicide 6 Could not be 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signat 29c. License number

Registrar

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

			for State Registrar	State of Mar		tificate of E		ina ivientai H	ygiene Reg. No.	016	. 00512
П	Physicia	ın/	1. Decedent's Name (First, Middle, Las	*	·	<u> </u>		2, Date of D	eath	Year	3. Time of Death
	Medic Examin	cal	Surjit Ka 4a. Facility Name (if not institution, give	street and number)		4b. City, Town, or	Location of	0.2	0 9	クロス unty of Death	
na si	į LAGIIII	Ci	University of Ma	ryland Me	dical Center	Baltim		Dou	40.000	inty of Death	1
	Funeral Director		5. Social Security Number 6. Se	7. Age (h	n yrs. last birthday)	If Under 1 Year Months Days	If Under 2 Hours	4 Hrs. 8. Date of B Min. (Month, L		9. Birtl Cou	hplace (State or Foreign intry)
			Usual Residence of Decedent	□ M 2 X F				July 1	8, 1949	,	India
	ryland I-f sho ied at	Director	10a, State 10b. County		Oc. City, Town or Loc						10d. Inside City Limits
	he Ma or 28a e notif		Maryland Anne Ar 10e. Street and Number	rundel		Odenton 10f. Zip Code			10g. Citizen	of What Co.	1 Yes 2 No
	with t	Funeral	501 Sugarberry Co	urt			113			India	
	death ritems inerm		11. Marital Status	12. Was Decedent Eve Armed Forces?	r in U.S. 13. V	Vas Decedent of His Yes, specify Cuba	spanic Origi n, Mexican,	in? (Specify Yes or No Puerto Rican, etc.))- 14. [Race - Amer Black, White	
036	s after al", or Exami	d by	1 ☐ Never Married 2 ☑ Married : 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🔯 No If Yes, Give Year or Dates.		☐ Yes 2 🛣 No			Spe		ian Indian
5-0	2 hour "natur	Completed	15. Decedent's Ed (Specify only highest gra	lucation	16a. Deced	ent's Usual Occupa	ation	of working	16b. Kind o	of Business/I	ndustry
121	thin 7; ene. than he Me	Som	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. DO	NOT use retired) Homemake	-	or working	Ora	n Home	
1d 2	Hygik Other	Be	10 17. Father's Name (First, Middle, Last)			пошешаке		's Name (First, Middle			
ylar	Id be f Menta arked atic ev	은	Tarlok Singh				Ba1wa	nt Kaur			
Mar	shou h and 7 is m traum		19a. Informant's Name/Relationship (Ty			-		or Rural Route Numb			*
e,	F Healt F Healt Item 2		Gurinder Singh/Sc 20a. Method of Disposition		20b. Place of Dispos	sition (Name of	1	t, Odento	T	Tand on - City or 1	
imo	Page Thent of ant: If i ury or		1 ☐ Burial 2 🔀 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		cemetery, crem West Cre	atory or other place Arundel ematory	e) F	ebruary 14 , 2012		,	aryland
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licens	TO MO	1296 Z2 D	Name and Addres	s of Facility Funer	al Home & Road, Oder			
			23a. Part 1. Enter the disease, or comp shock, or heart failure. List only or	lications that caused the						aryrar	Approximate
and the same	Physician		Immediate Cause (Final disease or condition		ionia.					50	Interval Between Onset and Death
March 1	Medical Examiner		resulting in death)	Due to (or as a co							
		ner	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a co	onsequence of):					-	
	cuted nd transit	Examiner	cause. Enter Underlying Cause (bisease or injury that initiated events	C							
	oe exec	alE	resulting in death) Last	Due to (or as a co	onsequence of):						
3760	ificate be executed g physician and as the burial-transit	ledic		d							
89 ×	attending for use a	an/N	23b. Was decedent pregnant	23c. If yes, outcome of g 1 ☐ Live Birth 2 ☐		Ectopic pregnanc	v		23d.	Date of deli	very
P.O. Box 68	To the Hospital or Attending Physician: The law requires that the death certil within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use it	Completed by Physician/Medical	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 🔀 Unknown	4 ☐ Pregnant at tir 9 ☐ Unknown		Other (specify)	,			Month	Day Year
P.0	s that the	by PI	Part II. Other significant conditions co	ntributing to death but r	not resulting in the u	nderlying cause giv	en in Part I.				the cause of death?
rds,	equire; een się hould I	eted		1-2				1 🗆	Yes 2 N	o 3 🗌 Pro	obably 4 💢 Unknown
Division of Vital Records,	e law r e has b	Jdwc							s an 24 opsy formed?	prior to co death?	opsy findings available ompletion of cause of
a B	an: Th tificate tor, pe		25. Was case referred to medical			26. Pla	ace of Death	(Check only one)	2 No	1 \(\text{Yes}	2 No
Ζ̈̈́	hysical his ce al direc	은	1 Li Yes 2 No		2 ER/Outpatien	t 3 DOA Othe	r: 4 🗆 Nur:	sing Home 5 Res	idence 6 🗆 0	Other (Specil	5y)
n of	ding P. h. After t funera	ate:	27. Manner of Death 1. Natural 5 Pending	28a. Date of injury (Month, Day, Ye	28b. Time of injury	28c. Injury work? M 1 🗆			how injury occ	urred	
isio	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury	- At home, farm, stre			28f. Location		mber or Rura	al Route Number,
<u>S</u>	urs after ral Direc			building, etc. (S					wn, State)		
	To the Hospital within 24 hours a To the Funeral C completely filled	Medical	(Check 2 Medical Examin	ician: To the best of my ner: On the basis of exam e Practitioner: To the be	nination and/or investi	gation, in my opinio	n, death occ	urred at the time, date	and place, and	due to the ca	ause(s) and manner stated.
	To the within To the comp		29b. Signature and title of certifier	(/)/	sat of my knowledge,	29c. License	number	and place, and dde to	29d. Date sig	ned (Month,	Day, Year)
			> 4H	X 1175		224	405		02/	09/2	2012-
			30. Name and address of person who c My-Le Pgyyen 22		(Item 23a) (Type, Pr	rint) himure r	1D 21	201			
	Stat		31. Date filed (Month, Day, Year) FEB 1 3 2012	2. Registrar's	Signature						
	Registra	.11	4 0 7017	A Black Black of	M. BRAL						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Dennis Keener Month O 2 1221 PM Oq 2012 Medical give street and number) 4a. Facility Name (if not institution, Examiner 4b. City, Town, or Location of Death 4c. County of Death Maryland Of University Baltimore N/A Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 220-82-8893 **Director** 1 XM 2 🗆 F 51 March 16,1960 Maryland Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at filed within 72 hours after death with the Maryland 10a, State 10c. City, Town or Location 10d, Inside City Limits Director MD 1 Yes 2 No Baltimore Dunda1k 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3463 Yorkway 21222 United States 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian. Black, White, etc. "natural", or 1 Never Married 2 Married þ X Yes Baltimore, Maryland 21215-0036 2 No 1 ☐ Yes 2 🗷 No Specify. If Yes, Give 3 Widowed 4 A Divorced White Completed Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) 2 should be filed within 72 h and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed withir Department of Health and Mental Hygiene Important. If item 27 is marked other the any injury or other traumatic event, the I Truck Driver Trucking 10 Years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James A. Keener, Sr. Betty M. Gandee 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3463 Yorkway Dundalk, Maryland 21222 Karen Capaldi (Sister) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🛣 Burial 2 □ Cremation 3 □ Removal from State Oak Lawn Cemetery 2/7/2012 4 Donation 5 Other (Specify) Baltimore, Maryland 21. Signatu e Funeral Service License Buda Ruck Funeral Home of Dundalk, Inc. Wise Ave Dundalk, Maryland 23a. Part 1. Enter the disease, or shock, or heart failure. List complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Peritonitis Onset a d Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Exami Cause (Disease or injury that initiated events resulting in death) Last nding physician and use as the burial-trans Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 use as IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ____ Month Pregnant at time of death the i 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has page 2 autopsy death? 1 ☐ Yes 2 ☐ No __ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2/No 1 🗌 Yes မ 4 Nursing Home 5 Residence 6 Other (Specify, Inpatient 2 - ER/Outpatient 3 - DOA within 24 hours after death.

To the Funeral Director: After this funeral 28a. Date of injury (Month, Day, Year) Certificate: Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 5 Pending 2 🗌 No Accident Investigation filled in by the 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a, Certifier 1/Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) 1699900878 M.D. 2 4 2012

State Registrar Jessica

31. Date filed (Month, Day,

Galey

M.D. 22 South Green St. Battimore MO 21701

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar 03944 Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ FEBRUARY 8 2012 VICTOR KOVENS 12:27P ^M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 3440 ASSOCIATED WAY, OWINGS MILLS BALTIMORE Social Security Number **Funeral** 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Birthpic. Country) Days 1 👿 M 2 🗆 F 01/31/1945 **Director** 212-42-3714 67 Yrs. Usual Residence of Decedent 28a-f show other traumatic event, the Medical Examiner must be notified at 10a, State 10b, County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD BALTIMORE OWINGS MILLS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 3440 ASSOCIATED WAY, 21117 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian If Yes, specify Cuban, Mexican, Puerto Rican, etc. ģ 1 Never Married 2 X Married Black, White, etc. 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify; "natural", Completed 3 Widowed 4 Divorced Specify: Year or Dates WHITE 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) other than Elementary/Seconday (0-12) College (1-4 or 5+) TRAVEL AGENT TRAVEL Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) nd Mental H ပ IRVIN KOVENS **JEAN** GOLDSTEIN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 i MICHAEL KOVENS / BROTHER 6 REGENCY COURT, BALTIMORE, MD 21208 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important: If ite
any injury or ot 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal-from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) SHAAREI TFILOH CONG. 02/10/2012 WOODLAWN, MD 21. Signature of Funeral Service License 22. Name and Address of Facility SOL LEVINSON & BROS., INC. WW 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Medical resulting in death) Examiner Sequentially list conditions Due to jor as a nonnectionne of cause. Enter Underlying Exami Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Pregnant at time of death Day Year Yes 2 No 9 Unknown 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an performed? Yes 2 No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: I within 24 hours after death.

To the Funeral Director: After this certifics Be 25. Was case referred 26. Place of Death (Check only one) examiner? Hospital: 2 No Other: မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natura! 5 Pending work? 1 Yes 2 🗌 No 2 Accider
3 Suicide Accident Investigation the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide completed filled in by determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, dearn occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 29b. Signature and title of certific D18987

Registrar DHMH 17 Rev 7/2009

State

68760

Box (

P.O.

Records,

Division of Vital

LOCK RAVENBLUD

BALTO, MD 21239

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5601

SPERLING, M.D.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Pebruary 10, 2012 Frances M. Luken 3:58 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Hospice Columbia Howard Social Security Number 8. Date of Birth (Month, Day, Year) 1/29/1928 **Funeral** If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Director 1 □ M 2**X** F 220-20-5939 84 Maryland 28a-f show 10a, State 10b. County must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 XNo Baltimore Catonsville 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? Funeral 713 Maiden Choice Lane, Apt. 1308 21228 USA permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items; any injury or other traumatic event, the Medical Examiner mus once. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 XNo If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 X Widowed 4 □ Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Administrative Assistant Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Michael J. Zinkand Mary A. Brennan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia M. Glazier / Daughter 58 Chase Street, Westminster, Maryland 21157 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Ponation 5 X Other (Specify) Entombment Meadowridge Mem. PK 2/13/2012 Elkridge, Maryland re of Funeral Service Lieensee 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition MONTHS Medical resulting in death) Examiner Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE nse 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) for in the past 12 months? Month Pregnant at time of death Day Year 2 🔀 No 9 Unknown Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by EMPHYSEMA 1 X Yes 2 □ No 3 □ Probably 4 □ Unknown page 2 should CORONARY ARTERY DISEASE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performe Yes 2 No 1 Yes 25. Was case referred to medical the funeral director, Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 🗷 No Hospital Other: မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 🔀 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Director: After 1 🔀 Natural 5 Pending work? 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined within 24 hours a

To the Funeral C

completely filled Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 064395 FEBRUARY 10, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CEDAR LANE COLUMBIA, MD 21044 6336 DOBERMAN, MS DANIELLE

State

Registrar

31. Date filed (Month, Day, Year)

3 2012

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Month 11:00 AM Physician/ Februar G. Lietz Dolores Medical County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** rince George's Regional Hospital Laure .aurel If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** (Month, Day, ine 9, Days Months Hours Min. Pennsylvania 1925 1 M 2 XF 86 June **Director** 192-16-6762 Usual Residence of Decedent 10d. Inside City Limits "natural", or items 23a or 28a-f show 10c. City, Town or Location 10a. State 10b. County with the Maryland Injury or other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 X No Anne Arundel Laurel MD 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number Funeral 20724 Old Line Avenue 212 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. should be filed within 72 hours after death v and Mental Hygiene. is marked other than "natural", or items 14. Race - American Indian, 11. Marital Status Black, White, etc. þ 1 Never Married 2 M Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Ø 12th Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Helen McWilliams Harry Gartland 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any Injury or other trau once. Laurel, MD Old Line Avenue, Lawrence A. Lietz/Husband 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition cemetery, crematory or other place) 1X Burial 2 ☐ Cremation 3 ☐ Removal from State MD Veterans Cemetery 2/21/2012 Cheltenham, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Donaldson Funeral Home, P.A. 21. Signature of Funeral Service Licensee Laurel, MD 313 Talbott Avenue, M01103 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Sepsis Pnysician/ disease or condition Medical resulting in death) Due to (o as a consequence of): Distress Syndrome **Examiner** Respiratory Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Fibrillation signed by the attending physician and defeached for use as the burial-transit resulting in death) Last Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No Month Day Year 5 Other (specify) Pregnant at time of death 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4XXUnknown should be Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autonsv page 2 s has performed? death? 26. Place of Death (Check only one) within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 X No 1 Nnpatient 2 ER/Outpatient 3 DOA Certificate: To 28a. Date of injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at work?
1 Yes 2 No Natural 5 Pending Investigation Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier only one) 29d, Date signed (Month, Day, Year) 29b. Signature and time of certifier D41248 February 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Laurel Regional Hospita 7300 Van Dusen Road George I, OKana 31. Date filed (Month, Day, Year) 32 Registrar's Signature State parke

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			for State	State of Ma		epartment of		lental Hygi	ene	
			Registrar 1. Decedent's Name (First, Middle, L.			Certificate of	Death		g. No.	2 0001
ľ	Physicia Medi		Julia Tulia	J.	Loga	\wedge		2. Date of Death Month	Day, 9 Year Zo	3. Time of Death 4
,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Examir		4a. Facility Name (if not institution, give	1 . 01-	Colodo	4b. City, Town, o	or Location of Death		4c. County of Dea	ath (
	Funeral		5. Social Security Number 6.	Sex 7. Age	(In yrs. last birth	day) If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	Bult	irthplace (State or Foreign
	Director		248-70-6872 Usual Residence of Decedent	1 □ M 2 🔀 F	87 _Y	Months Days	Hours Min.	(Month, Day, Y		ountry)
	land f show d at	후	10a. State 10b. County		10c. City, Town	or Location		<u></u>		10d. Inside City Limits
	e Mary r 28a-	Sire(MD 10e. Street and Number		Balt	imore				tx☐ Yes 2 ☐ No
	s 23a o	Funeral Director	5200 Bowleys	Lane Apt	.208	10f. Zip Code 2120	6	10	g. Citizen of What C USA	country?
21215-0036	e filed within 72 hours after death with the Maryland ital Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	þ	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Ev Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates.		13. Was Decedent of Head of If Yes, specify Cub	an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi Specify: B 1	te, etc.
15-(72 hou n "nati Nedica	Completed	15. Decedent's (Specify only highest g	grade completed)		Decedent's Usual Occup Give kind of work done	during most of worki	ing 16	6b. Kind of Business	s/Industry
212	led within Hygiene. other than ent, the N		Elementary/Secondary (0-12)	College (1-4 or 5+))	fe. DO NOT use retired, urses' As	sistant		Home H	elp
Maryland	should be filed and Mental Hyg is marked oth aumatic event,	To Be	17. Father's Name (First, Middle, Last, Ciciero More				18. Mother's Name	e (First, Middle, Mai a Brid	,	
	2 ± 2 ± 1		19a. Informant's Name/Relationship (Julia Thomas	Type, Print) (daughte)	c) 56	Mailing Address (Street DO Force	and Number or Rura Rd Bal	Route Number, Ci	ity or Town, State, Z 21206	ip Code)
Baltimore,			20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 [4 ☐ Donation 5 ☐ Othe <u>r (Spec</u>	☐ Removal from State	comoton	Disposition (Name of crematory or other place) Sy Valley	nal i		oc. Location - City o	
Bal	permit. Page Department of Important: If any injury or once.	3	21. Signature of Julian Service ber	nsee		22. Name and Addre	Schulk	s Funer		
	h sician Medical Examiner		23a. Part 1. Enter the disease, or cor shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. TSU Due to (or as a c	consequence of	Cardion	ny opati	r respiratory arrest,		Approximate Interval Between Onset and Death
		iner	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a c		trieng D	sease			> yvs.
	ecuted and -transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a c	ertens	ion				>10 413,
092	cate be executed physician and s the burial-transit	edical E	Visional grand and Last	d						
687	ertifica ding ph se as t	/Me	IF FEMALE:	23c. If yes, outcome of	prednancy					
). Box 68	to the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. In the Functor After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	1 Live Birth 2 4 Pregnant at ti	Fetal death	3	ey		23d. Date of de Month	elivery Day Year
Division of Vital Records, P.O.	equires that sen signed I ould be det	by	Part II. Other significant conditions	contributing to death but	not resulting in	he underlying cause gi	Huits,	23e. Did tobad	20	o the cause of death?
Recol	sician: The law re s certificate has be director, page 2 sh	Completed	pen premi Vas	war Disea	se			24a. Was an autopsy performe 1 Yes 2	prior to death?	utopsy findings available completion of cause of
/ital	sician s certif directo	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	0 T 57/0 :	Oth	ace of Death (Check			
on of	nding Phys ath. : After this e funeral di		27. Manner of Death 1 ★ Natural 5 ☐ Pending 2 ☐ Accident Investigation	28a. Date of injury (Month, Day, Y	28b. Tin	ry work	/at 2	ne 5 ∐ Residenc 8d. Describe how i	e 6 Other (Specinjury occurred	ify)
Division	of the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director. After this certific completely filled in by the funeral director.	Certificate:	3 Suicide 6 Could not to determined	De Diogo of Injury		, street, factory, office		28f. Location (Stree City or Town, S	t and Number or Ru tate)	ral Route Number,
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical	(Check 2 ☐ Medical Exam	vsician: To the best of my niner: On the basis of exar se Practitioner: To the b	mination and/or in	vestigation, in my opinio	n, death occurred at	the time date and n	lace and due to the	cause(s) and manner stated
	Not Not Coa		29b. Signature and title of certifier	Martin	20/4	RWP 29c, License			Date signed (Monti	
			30. Name and address of person who	completed cause of deat	th (Item 23a) (Typ	pe, Print)	6701 N	Modes	St; Bulto	MD 21204
	Stat Registra	e ir	FEB 1 3 2012	32. Registra's	Signature	•			/	

DHMH 17 Rev 06-2011

expired at 12:15 PM

Julia Logan

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Geraldine Viola Lyons М Medical 4a. Facility Name (if not institution, give street and number) **Examiner** or Location of Death 4c. County of Death N/A 7. Age (In vrs. last birthday) **Funeral** If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 1 ... M 2 ... F Days Hours **Director** Yrs 1270371947 S. Carolina 212-48-0222 64 Usual Residence of Decedent show ed other than "natural", or items 23a or 28a-f shorevent, the Medical Examiner must be notified at 10a. State 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits Yes 2 No MD N/A Baltimore 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 109 N. Hilton St. 21229 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Bace - American Indian Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: Black Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) 12th Grade College (1-4 or 5+) Factory Miss Filberts permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygiei Important: If item 27 is marked other i any injury or other traumatic event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ္ **Emmanuel Harrington** Azalee Mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sandra McSwain(daughter) Hilton St., Baltimore, MD 21229 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cem. 02/18/12 Baltimore, 21. Signature of Juneral Service License 22 Name and Address of Facility Joseph H. Brown Jr. 2140 N. Fulton Ave., Funeral Home PA Baltimore, MD21217 ▶ 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ Due to (or as consequence of): disease or condition Medical Examiner resulting in death) Sequentially list conditions, Examiner Due to (or as a consequence of): If any, leading to firm edicause. Enter Underlying Cause (Disease or linjury that initiated events and -tran Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial-Physician/Medical that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death signed by the at d be detached for 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ş Vancrectic Concer Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 No 1 Yes 2 No 1 Yes Division of Wital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 Other: 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) After this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No filled in by the 1 2 Accident 3 Suicide Investigation within 24 hours after deat To the Funeral Director: 6 🗆 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 🗌 Homicide City or Town, State) Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 170053849 s of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (/

Registrar's Signa

		1	For State Registrar	2.31		,		rtificat				lental H	Reg. N	0.7	11:	2 039
Phys	sician		1. Decedent's Name (First, Middle									Date of D Month		Day	Year	3. Time of De
•	edical		Charlie Moore									3	9) 5	2019	
Exan	miner		a. Facility Name (If not institution		1 1	a 1				Location	of Death			C. County		
Funer	ral	5	Franklin Squa . Social Security Number	6. Sex	7. Age	(In yrs. las	t birthday)	If Under		If Under		8. Date of B	-Ab	Bal-	9. Birt	hplace (State or Fo
Direct			INFANT	1□M 2🏻	1 F		Yrs.	Months	Days	Hours 6	5 ^{Min.}	Feb 2,	20.	12		untry) ryland
A T		-	Usual Residence of Decedent Oa. State 10b. County			10c. City, 7	Town or Lo	cation								10d. Inside City L
f sho	ğ		MD				ltimo									1 ∰Yes 2[
23a or 28a-f show	Director	1	0e. Street and Number					10f. Zip					10g. (Citizen of V	Vhat Co	untry?
23a o	alD		127 Henriett	a St.				21	230					USA		
natural", or items 23a or 28a-f show	Funeral	1	1. Marital Status	12. Was	Decedent E	ver in U.S.	13.	Was Deced	dent of H	ispanic Or	igin? (Sp	ecify Yes or N Rican, etc.)	0-		e - Ame	rican Indian,
al", or items	by Fi		1 Never Married 2 Marri 3 Widowed 4 Divorced	ied 1 🔲	Yes 2∭XN s,Give	0		1 □ Yes	W.	Specify.		,,		Specify	1, 1	ack
"natural",	ed		15. Decedent		r or Dates:		16a. Dece	dent's Usua	al Occup	ation			16b.	Kind of Bu	ısiness/l	ndustry
e. an "ng	plet	-	(Specify only highes Elementary/Secondary (0-12)	st grade comple	eted) ege (1-4or 5-		(Give	kind of wor DO NOT us	rk done c	turina mos	t of work	ing				,
ygien ygien er th	Completed		INFANT		NFANT			INFA	NT					INF	ANT	
ad oth	Be	1	7. Father's Name (First, Middle,	Last) unk								Maaraa	e, Maide	en Surnam	ie)	
d Mer marke	၉		10a lafarmanika ilama /Dalatianak	in (Euro Brita)			405 44-11		(0)			Moore	0	-	0	
Ith an 177 is i		P	19a. Informant's Name/Relationsh Tanika Moore					-				al Route Num Balti				
item 2		2	20a. Method of Disposition			20b. Plac	ce of Dispo	sition (Nan	ne of			Date				Fown, State
nent c int: If			1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 🔀 Other (Si			Celli	ieleiy, ciei	natory`or o	uitei piac							
				gecity) in S	tate				,	1						
permit. Tagges I aim 2 should be med writin if a rio Department of Heart Mandal Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Madical Call.	once.	2	21. Signature of Funeral Service I	-	111	octor	22		nd Addres	ss of Facili		ite Ana St; Ba		-		21201
Departr Importa any inji	once.		21, Signature of Funeral Service I	S Wase	St.			655	nd Addres	ss of Facili	nore	St; Ba	lti	-		Approximate
Departs Departs Imports any inji		1	21. Signatur of Funeral Service 23a. Part 1. Enter the disease, or shock, or heart failure. List immediate Cause Hal	S Wase	that caused on each line	the death.	Do not ent	655 ter the mod	W • B	ss of Facili altir g, such as	nore	St; Ba	lti	-		
hysicia /Medica	an eal	1	21. Signature of Funeral Service 123a. Part 1. Enter the disease, of shock, or heart failure. List immediate Cause Floal	complications to only one cause	St.	the death.	Do not ent	655	W • B	ss of Facili altir g, such as	nore	St; Ba	lti	-		Approximate Interval Between
hysicia	an eal er	i	21. Signatur of Funeral Service 23a. Part 1. Enter the disease, of shock, or heart failure. List immediate Cause Unal disease or condition resulting in death)	complications to only one cause Du	that caused to on each line the to (or as a	the death. e.	Do not ent	655 ter the mod	W • B	ss of Facili altir g, such as	nore	St; Ba	lti	-		Approximate Interval Between
hysicia /Medica xamine	an eal er	i	21. Signature of Funeral Service 23a. Part 1. Enter the disease, of shock, or heart failure. List immediate Cause tipal disease or condition resulting in death) Sequentially list conditions, fam, leading to immediate cause. Enter Uncurrying Cause (Disease or injury)	complications to only one cause Du	that caused on each line	the death. e.	Do not ent	655 ter the mod	W • B	ss of Facili altir g, such as	nore	St; Ba	lti	-		Approximate Interval Between
hysicia /Medica xamine	an eal er	i	21. Signature of Funeral Service 123a. Part 1. Enter the disease, of shock, or leart failure. List immediate Cause Hall disease or condition resulting in death) Sequentially list conditions, famy, leading to immediate a	complications to only one cause a. E. Du b	that caused to on each line the to (or as a	the death. e. consequer	Do not enter proceed of:	655 ter the mod	W • B	ss of Facili altir g, such as	nore	St; Ba	lti	-		Approximate Interval Between
hysicia /Medica xamine	er Examiner	Sili	21. Signature of Funeral Service 23a. Part 1. Enter the disease, or shock, or heart failure. List immediate Cause Final disease or condition resulting in death) Sequentially list conditions, and any, leading to immediate cause. Enter Underlying Cause (Disease or injury hat initiated events	complications to only one cause a. E. Du b	that caused on each line the to (or as a	the death. e. consequer	Do not enter proceed of:	655 ter the mod	W • B	ss of Facili altir g, such as	nore	St; Ba	lti	-		Approximate Interval Between
hysicia /Medica xamine	a la la la la la la la la la la la la la	Sili	21. Signature of Funeral Service 23a. Part 1. Enter the disease, or shock, or heart failure. List immediate Cause Final disease or condition resulting in death) Sequentially list conditions, and any, leading to immediate cause. Enter Underlying Cause (Disease or injury hat initiated events	c	that caused on each line to (or as a see to (or a see to (or	the death. e. consequer a consequer	Do not end Pre- pre- pre- pre- pre- pre- pre- pre- p	655 ter the mod	W • B	ss of Facili altir g, such as	nore	St; Ba	lti	-		Approximate Interval Between
hysicia /Medica xamine	a la la la la la la la la la la la la la	Sili	23a. Part 1. Enter the disease, of shock, or leart failure. List immediate Cause tipal disease or condition resulting in death) Sequentially list conditions, fany, leading to immediate cause. Enter Univerying Cause (Disease or injury hat initiated events resulting in death) Last FFEMALE: 23b. Was decedent pregnant in the past 12 months?	ensee Wask complications to only one cause a. E. Du b	that caused on each line to (or as a see to (or a see to (or a))))).	the death. consequer consequer consequer	Do not ent Pre nce of): nce of):	655 ter the mod mat	w Ble of dyin	alting, such as	nore	St; Ba	lti	-	MD	Approximate Interval Betwee Onset and Dea
hysicia /Medica xamine	a la la la la la la la la la la la la la	Sili	21. Signature of Funeral Service 123a. Part 1. Enter the disease, of shock, or leart failure. List immediate Cause Final disease or condition resulting in death) Sequentially list conditions, farty, leading to immediate cause. Enter Underlying Cause (Disease or injury hat initiated events esulting in death) Last FFEMALE: 23b. Was decedent pregnant	ensee W complications to only one cause a. Du b. Du c	that caused on each line to (or as a see to (or a)))).	the death. consequer consequer consequer	Do not ent Pre nce of): nce of):	655 Mat	w Ble of dyin	alting, such as	nore	St; Ba	lti	more,	MD	Approximate Interval Betwee Onset and Dea
hysicia /Medica xamine	a la la la la la la la la la la la la la	Sill of the control o	23a. Part 1. Enter the disease, of shock, or heart failure. List immediate Cause that disease or condition resulting in death) Sequentially list conditions, fany, leading to immediate cause. Enter Univerying Cause (Disease or injury hat initiated events resulting in death) Last F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	b	that caused on each line to (or as a see to (or a se	the death. a consequer a consequer consequer consequer consequer	Do not ent Presente of): noe of): y eath 3 [th 5 [655 Mat Betopic p Other (sp	M · B de of dyin coregnancy	ss of Facili	nore s cardiac	St; Ba	arrest,	23d. Data Mo	MD	Approximate Interval Betwee Onset and Dea
hysicia /Medica xamine	a हैं ड by Physician/Medical Examiner	Sili Control of the c	23a. Part 1. Enter the disease, of shock, or heart failure. List immediate Cause Heart disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter University Cause (Disease or injury hat initiated events resulting in death) Last FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	b	that caused on each line to (or as a see to (or a se	the death. a consequer a consequer consequer consequer consequer	Do not ent Presente of): noe of): y eath 3 [th 5 [655 Mat Betopic p Other (sp	M · B de of dyin coregnancy	ss of Facili	nore s cardiac	St; Ba or respiratory	arrest,	23d. Dat Mo	MD te of delianth	Approximate Interval Betwee Onset and Dea
s been signed by the attending physician and second by the attending physician and second by the detached for use as the burial-transit	의 한 명 한 명 한 명 한 명 한 명 한 명 한 명 한 명 한 명 한	Sili Control of the c	23a. Part 1. Enter the disease, of shock, or heart failure. List immediate Cause Heart disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter University Cause (Disease or injury hat initiated events resulting in death) Last FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	b	that caused on each line to (or as a see to (or a se	the death. a consequer a consequer consequer consequer consequer	Do not ent Presente of): noe of): y eath 3 [th 5 [655 Mat Betopic p Other (sp	M · B de of dyin coregnancy	ss of Facili	nore s cardiac	St; Ba or respiratory 23e. Did 1 24a. Wa	tobacco	23d. Date Moo	MD te of delimith ribute to 3 □ Pr	Approximate Interval Betwee Onset and Dea
ate has been signed by the attending physician and managed 2 should be detached for use as the burial-transit	ompleted by Physician/Medical Examiner	Sili Control of the c	23a. Part 1. Enter the disease, of shock, or heart failure. List immediate Cause Heart disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter University Cause (Disease or injury hat initiated events resulting in death) Last FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	b	that caused on each line to (or as a see to (or a se	the death. a consequer a consequer consequer consequer consequer	Do not ent Presente of): noe of): y eath 3 [th 5 [655 Mat Betopic p Other (sp	M · B de of dyin coregnancy	ss of Facili	nore s cardiac	23e. Did 1 24a. Wa aut	tobaccell Yes s an oppsy formed?	23d. Date Moo	MD te of deliverable to a superior to a death?	Approximate Interval Betwee Onset and Dea
ate has been signed by the attending physician and managed 2 should be detached for use as the burial-transit	ompleted by Physician/Medical Examiner		23a. Part 1. Enter the disease, of shock, or heart failure. List immediate Cause Heart disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter University Cause (Disease or injury hat initiated events resulting in death) Last FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	ensee Wase complications to only one cause a. E. Du b. Du c. Du d. 23c. If yee 1 9 9	that caused on each line to (or as a see to (or a se	the death. a consequer a consequer consequer consequer consequer	Do not ent Presente of): noe of): y eath 3 [th 5 [655 Mat Betopic p Other (sp	d Addres W B de of dyin oregnancy pecify) ause give	ss of Facilities alting, such as	nore s cardiac	St; Ba or respiratory 23e. Did 1 □ 24a. Wa aut	tobaccellyes san poppsy 2 M	23d. Date Moo	MD te of deliverable to a superior to a death?	Approximate Interval Betwee Onset and Dea
this certificate has been signed by the attending physician and manipolarial director, page 2 should be detached for use as the burial-transit	e व व व व व व व व व व व व व व व व व व व		23a. Part 1. Enter the disease, of shock, or learnt failure. List immediate Cause Horal disease or condition resulting in death) Sequentially list conditions, I any, leading to immediate cause. Enter University Cause (Disease or injury hat initiated events resulting in death) Last FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions are caused.	ensee Ware complications to only one cause a. E. Du b. Du c. Du d. 23c. If yes 1 4 9 9 9 9 9 9 9 1 1 1 1 1 1 1 1 1 1 1	that caused to on each line to (or as a see to (or a))))))).	the death. a consequer a consequer consequer consequer to resulting t not resulting	Do not ent Property Ince of): Ince o	655 ter the mod Contact Con	oregnancy ause give	ss of Facilities alting, such as the property of the property	nore cardiac	23e. Did 24a. Wa aut per 1 Yes n (Check only)	tobaccollyes s an opsy formed? 2 one)	23d. Dath Mo	MD te of delighth to the state of delighth to the state of death? Were autorior to death? I □ Yes er (Special Special pproximate Interval Betwee Onset and Dea	
this certificate has been signed by the attending physician and manipolarial director, page 2 should be detached for use as the burial-transit	e व व व व व व व व व व व व व व व व व व व		23a. Part 1. Enter the disease, of shock, or leart failure. List immediate Cause Inal disease or condition resulting in death) Sequentially list conditions, fany, leading to immediate cause. Enter Underlying Cause (Disease or injury hat initiated events esulting in death) Last F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions of the conditions	ensee Was complications to only one cause a. Du b. Du c. Du d	that caused to on each line to (or as a see to (or a see	the death. consequer consequer consequer consequer consequer consequer trace to the consequer trace to the consequer trace to the consequer trace to the consequer trace to the consequer trace to the consequer trace to the consequer trace to the consequer trace to the consequer trace to the consequer trace to the consequer trace to the consequer trace to the consequer trace to the consequer trace to the consequer trace to the consequer trace trace to the consequer trace	Do not ent Presente of): noe of): y eath 3 [th 5 [Ectopic p Other (sp	oregnancy oreginal ause give	alting, such as	nore cardiac	23e. Did 24a. Wa aut per 1 Yes	tobaccollyes s an opsy formed? 2 one)	23d. Dath Mo	MD te of delighth to the state of delighth to the state of death? Were autorior to death? I □ Yes er (Special Special pproximate Interval Betwee Onset and Dea	
ate has been signed by the attending physician and barriers in its property of the contraction of the contra	ompleted by Physician/Medical Examiner		23a. Part 1. Enter the disease, of shock, or leart failure. List immediate Cause tipal disease or condition resulting in death) Sequentially list conditions, fany, leading to immediate cause. Enter Underlying Cause (Disease or injury hat initiated events resulting in death) Last FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions of the past 12 months? 1 Yes 2 No 9 Unknown 25. Was case referred to medical examiner? 1 Yes 2 No 25. Was case referred to medical examiner?	ensee W complications to only one cause a. Du b. Du c. Du d. 23c. If yet 9 Phospital: 28a. dation	that caused on each line to (or as a set to (or a)))))).	the death. consequer consequer consequer consequer consequer consequer trot resultir trot resultir	Do not ent Presented of the control	Ectopic p Other (sp	oregnancy oreginal ause give	ss of Facilities alting, such as the property of the property	nore cardiac cardiac	23e. Did 1 24a. Wa aut per 1 Yes 1 (Check only me 5 Re- 28d. Describe	tobacce lyes s an opsy formed? 2 one) sidence how in	23d. Dath Moo	MD te of delimith ribute to 3 Pr Were au prior to c death? t Yes er (Speced	Approximate Interval Betwee Onset and Dea

State Registrar MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)
FEB 1 3 2012

29c. License number

D67337

9000 Franklin Square Drive Baltimore, MD 21237
Registrar's Signature

29d. Date signed (Month, Day, Year)

February 2,2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For	State of Marylan	d / Department of H	lealth and M	lental Hyg	giene	
			State Registrar		Certificate of L	Death	F	Reg. No. 2012	03950
	Physicia Medio		1. Decedent's Name (First, Middle, Last		Memphis		2. Date of Dea Month	Day 8 Zuiz	3. Time of Death 0342 M
-	Examin	er		kins Hospita	el Balt	Location of Death	ity	4c. County of Death	
	Funeral Director		5. Social Security Number 6. Sec. 217–40–3313 1 Dusual Residence of Decedent	7. Age (In yrs. la	ast birthday) If Under 1 Year Months Days Yrs.	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	9. Birthp Count 1, 1943	olace (State or Foreign try) Maryland
	and show	호	10a. State 10b. County		y, Town or Location	<u> </u>	000. 3.		0d. Inside City Limits
	Mary 28a-f otifie	Director	MD Harford	Fall	ston				1 ☐ Yes 2 🔀 No
	ith the 3a or it be n		10e. Street and Number		10f. Zip Code			10g. Citizen of What Coun	try?
	ems armus	Funeral	1314 Terry Way	12. Was Decedent Ever in U.S		spanic Origin? (Spec	cify Yes or No-	USA 14. Race - America	an Indian
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ρ	1 ☐ Never Married 2 ☐XMarried 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates.	If Yes, specify Cuba 1 ☐ Yes 2🌠 No	n, Mexican, Puerto F	Rican, etc.)	Black, White, e	etc.
15-0	72 hou "natu edical	Completed	15. Decedent's Edu (Specify only highest grad	cation e completed)	16a. Decedent's Usual Occup- (Give kind of work done of		ng	16b. Kind of Business/Inc	
121	vithin 7 iene. r than	Com	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. DO NOT use retired) Receptionist	3		Home Improve	mont Co
pu	filed wall Hyg	Be	17. Father's Name (First, Middle, Last)		Receptionist	18. Mother's Name			meric co.
ylaı	Menta Menta narked	မ	James Latgis			Paula Ima	schweile	er	
Mai	2 shouth and the and the strain traum	H	19a. Informant's Name/Relationship (Type Ernest Memphis	e, Print) / husband	19b. Mailing Address (Street a				ode)
ē,	1 and of Heal item		20a. Method of Disposition	20b. P	lace of Disposition (Name of		_	21047 20c. Location - City or To	wn, State
imo	Page ment c ant: If ury or		1 Burial 2 Cremation 3 F 4 Donation 5 Other (Specify)		emetery, crematory or other plac Demetrios_Gree	1	/2012	Cub Hill. MD	
Balt	permit. Depart Import any inj		21. Signature of Fine 1 5 ryug 17, nse	0	22. Name and Addres	s of Facility		1050 Y	ork Road
			23a. Part 1. Enter the disease, or compli	cations that caused the death	Ruck Towson Do not enter the mode of dying				, MD 21204 Approximate
ginis.	Physician/		shock, or heart failure. List only one Immediate Cause (Final disease or condition		n				Interval Between Onset and Death
1	Medical Examiner		resulting in death)	Due to (or as a consequent					
b		Jer	Sequentially list conditions, if any, reading to immediate	Due to for as a consequence	90) ence of):				
	uted Id ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events		yeloid luker	nia			
	ate be executed ohysician and the burial-transit	al Ex	resulting in death) Last	Due to (or as a conseque		-			
2092	icate b g physi as the t	ledical							
89 ×	death certificate be executed he attending physician and led for use as the burial-transi	ian/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	dc. If yes, outcome of pregnar 1 ☐ Live Birth 2 ☐ Fetal	ncy I death 3 🗆 Ectopic pregnanc	У		23d. Date of delive	
P.O. Box 687	the deal	Physician/Me	1 Yes 2 No 9 Unknown	4 ☐ Pregnant at time of de 9 ☐ Unknown	eath 5 Other (specify)			Month	Day Year
s, P.C	requires that the de been signed by the should be detached	þ	Part II. Other significant conditions con	tributing to death but not resu	ulting in the underlying cause giv	en in Part I.	23e. Did tob	pacco use contribute to the	e cause of death?
Records,	w requi	Completed					24a. Was ar		sy findings available
Rec	The law ate has page 2	Som	7,000				autops perform 1 \(\sum \) Yes 2	ned? death?	npletion of cause of
ţ	sician: The certificate irector, paç	Be	25. Was case referred to medical examiner?	pspital;	26. Pla	ice of Death (Check			
<u>ر</u>	y Physer this eral di	e: 10	1 ✓ Yes 2 ☐ No He 27. Manger of Death	28a. Date of injury	ER/Outpatient 3 DOA 28c. Injury	4 ☐ Nursing Hon		nce 6 Other (Specify) w injury occurred	
OU (tending I leath. or: After the funer	ficat	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	injury work?	Yes 2 No			
Division of Vital	Hospital or Attending Physician: The law requires that the 44 hours after death. Funeral Director: After this certificate has been signed by the stely filled in by the funeral director, page 2 should be detach	Certificate:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At hon building, etc. (Specify)	ne, farm, street, factory, office	2	8f. Location (Str City or Town,	reet and Number or Rural I , State)	Route Number,
	To the Hospital or within 24 hours aft. To the Funeral Dir completely filled in	edical	(Check 2 L Medical Examine	r: On the basis of examination	edge, death occurred at the time and/or investigation, in my opinion y knowledge, death occurred at th	 death occurred at t 	he time date and	diplace, and due to the caus	se(s) and manner stated
	To the within 2 To the comple	Σ	29b. Signature and title of certifier	/	29c. License	number	e, and due to the	9d. Date signed (Month, D	ay, Year)
			Finly Dr	Man	RES-	-000	F	ebruay 8	,2012
3			30. Name and address of berson who col Emily Brighan	npleted cause of death (Item 2	29c. License PES - 23a) (Type, Print) 600 N.	Intole 11	Back	m Mi	70.07
1	Stat	е	31. Date filed (Martin Bay, Year) 2012	2. Registrar's Signat	ire backer	voore si	· Own	110012 110	2-01
	Registra	ır	I ED I O SOL	Central 15.	7				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ OTIOAM BABY MOORE BOY Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death CROSS SILVER HOL MONTGOMERY SPRING Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Birthplace (State or Foreign Country) (Month, Day, 1 M 2 - F Davs Min Director N 0 Usual Residence of Decedent 28a-f show 10a. State the Maryland 10c. City. Town or Location Director 10d. Inside City Limits be notified MD 1 Yes 2 No SILVER SPRING MONTGOMERY 23a or 2 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral CLOVER 209 SVA 0 SWEET DK items? permit. Page 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner m 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Completed 3 Widowed 4 Divorced Year or Dates. N BLACK 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) INFANT INFANT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ BARLAST CALEB FEMI DANNETTE MIRIM 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HOLY CROSS HOSPITA FOREST CLEN RD SILVER SPRING HD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place 5 NOther (Specify) in state Ron S Signato 22. Name and Address of Facility State Anatomy Board Director 655 W. Baltimore St; Baltimore, MD 21201 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician PRE-VIABLE disease or condition resulting in death) OWK GESTATION Medical Due to (or as a consequence of) Examiner OW Sequentially list conditions Examiner cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last attending physician and for use as the burial-trans Due to (or as a consequence of): Physician/Medical The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 L Fetal deat
Pregnant at time of death
Unknown 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Day Year ned by the are detached for 1 Yes 2 L 9 Unknown sate has been signed by page 2 should be detack Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? the Hospital or Attending Physician: The thin 24 hours after death.

The Funeral Director: After this certificate the Funeral Director. 1 Yes 2 No completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 ☑ No Other: ျပ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Man r of Death Date of injury 28b. Time of Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify) within 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To he best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar 31. Date filed (Month, Day, Year)

FEB 1 3 2012

DHMH 17 Rev 7/2009

4000 MITCHELLVILLE RD;

BOWLE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

		For State Registrar		State of M		d / Depa		t of H	lealth		/lental Hy		201	2 0395	2
Physicia Medic		1. Decedent's Name (First, Jacqueline	,								2. Date of Dea	ath	2012	3. Time of Death /903 M	1
Examin		4a. Facility Name (if not ins	stitution, give str	eet and number)	1 1	ake	4b. City,		Location		,	/ 4c.	. County of De <i>KILCOM</i>	ath • (/Ci)	
Funeral Director		5. Social Security Number 214-66-991 Usual Residence of Dece	9 6. Sex			st birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	/	8. Date of Birt (Month, Da Jan 23	h /, Year) 19.	54 g. B	irthplace (State or Foreign ountry) laryland	7
Maryland 28a-f show otified at	Funeral Director	10a. State 10b.	County Wicomic	0	'	, Town or Loc	cation							10d. Inside City Limits 1 ☐ Yes 2 🔀 No	
with the s 23a or ust be n	eral D	10e. Street and Number 112 N. Ch	urch St				10f. Zip	Code 1830				_	tizen of What ${\sf CSA}$	Country?	
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status 1 Never Married 2 3 Wildowed 4 D	X Married	2. Was Decedent Armed Forces? 1 Yes 2 2 If Yes, Give Year or Dates.	Ever in U.S	1f	Vas Deced Yes, spec	ify Cubai	n, Mexica	n, Puerto	ecify Yes or No- Rican, etc.)		14. Race - Am Black, Wh Specify: W		
ithin 72 hour ene. • than "natu he Medical	Completed		Decedent's Educ ly highest grade (0-12)		5+)		ent's Usua aind of wor O NOT use	k done d		st of work	ing	16b. K	ind of Busines	-	
be filed w ental Hygi ked other ic event, t	To Be (17. Father's Name (First, N				ICIV					e (First, Middle, izabeth		Surname)	care	
d 2 should alth and M 27 is mar er traumati		19a. Informant's Name/Re William M									al Route Numbe			Zip Code)	_
Page 1 an ment of He ant: If iten ury or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cre 4 ☒ Donation 5 ☐	mation 3 🗆 Re	emoval from State		lace of Disposemetery, crem			e)		Date	20c. Lo	ocation - City o	or Town, State	
permit. Depart Import any inj		21. Signature of Funeral S Rona	nvice Licensee	Milli	ecto	22.					ate Ana St; Ba	-		21201	
Physician/ Medical		23a. Part. Enter the dise shock of heart failur Immediate Cause (Final disease or condition resulting in death)		ations that cause cause on each lin Due to (or as	o. Ina	Car	r the mode		g, such as	cardiac o	or respiratory am	rest,		Approximate Interval Between Onset and Death	
Examiner	iner	Sequentially list condition if any, leading to immedia cause. Enter Underlying		Due to (or as	a consequ	ence of):									
be executed sician and burial-transit	cal Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C .	Due to (or as	a consequ	ence of):					· v				_
irtificate ling phys se as the		IF FEMALE:	d.	c. If yes, outcome	of progna	2004									_
To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the	by Physician/Medi	23b. Was decedent pregna in the past 12 months 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	ALIL	1 Live Birth 4 Pregnant	2 Fetal	Ideath 3 🗌	Ectopic p Other (sp		у				23d. Date of d Month	elivery Day Year	
uires that t in signed b uld be deta		Part II. Other significant of	conditions cont	ributing to death I	out not resu	ulting in the ui	nderlying o	ause giv	en in Part	I.				to the cause of death? Probably 4 🙀 Unknowr	n
The law req ate has bee page 2 sho	Completed										24a. Was autop perfo 1 Yes		prior to death?	utopsy findings available completion of cause of es 2 \square No	
ician: certifica rector,	Be	25. Was case referred to n examiner?		spital:				26. Pla		ath (Checi	k only one)				
g Phys er this eral di	e: To	1 ☐ Yes 2 🗶 No 27. Manner of Death		1 M Inpat 28a. Date of inju	ıry	ER/Outpatien 28b. Time of		Bc. Injury	4 LIN		ome 5 Residence 128d. Describe h			ecify)	_
eath. or: Afte the fun	ficat	2 Accident	Pending Investigation Could not be	(Month, Da	ly, Year)	injury	М	work	? Yes 2 □] No					
ital or Att urs after d ral Direct	al Certificate:	4 Homicide	determined	28e. Place of Inj building, et			et, factory	office			28f. Location (S City or Tow			ural Route Number,	
the Hosp hin 24 hou the Fune npletely fi	Medical	(Check 2 Me only one) 3 X Ce	edical Examine rtifying Nurse I	an: To the best on the basis of erractitioner: To the	examination	and/or investi	igation, in r death occi	ny opinio irred at th	n, death o ne time, da	ccurred a	t the time, date a ace, and due to t	nd place he cause	e, and due to the e(s) and manner	e cause(s) and manner state as stated.	ed.
Voit Voit COr		29b. Signature and title of	Wild	man	Α,	CRM	0	License (j)	number 104	600	7	29d. Da	te signed (Mor	th, Day, Year)	
		30. Name and address of Paige Wild	dmann	pleted cause of a				lisb	ury	m	1.21801				
Stat		31. Date filed (Month, Day,	Year) 3 2012	32 Registr		A South	Mad)	,					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For	State of M	aryland / Dep			Mental Hyg	iene		00050
			State Registrar		Ce	rtificate of D	eath	1	eg. No. 2	12	03933
	Physicia	an/	1. Decedent's Name (First, Middle,	,				2. Date of Deat	h Day 7	Year,	3. Time of Death
and the	Medic Examir		Charles Mello 4a. Facility Name (if not institution,			4b. City, Town, or	Location of Death	100	4c. County	of Death	1000 "
Company of the Contract of the	LAGIIII		Western Maryl	and Health	System	Cumbel			1	gany	
1	Funeral		5. Social Security Number	6. Sex 7. Ag	e (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth			ce (State or Foreign
	Director	l	214-48-2578 Usual Residence of Decedent	1 X M 2 □ F	64 Yrs.			March 7,	1947		land
	and show i at	o.	10a. State 10b. County		10c. City, Town or Lo	ocation				100	I. Inside City Limits
	Maryli 28a-f otifiec	irect	MD Wash	nington	Hagerst	own					1 ☐ Yes 2X No
	e filed within 72 hours after death with the Maryland tal Hyglene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Funeral Director	10e. Street and Number 222 W. Frank]	lin St. #1		10f. Zip Code 21740		1	0g. Citizen of W	/hat Country	/?
	ath wi	nnei	11. Marital Status	12. Was Decedent	Ever in ILS 13		spanic Origin? (Sp	ecify Yes or No-		- American	Indian
9	er deg or ite miner		1 Never Married 2 Marri	Armed Forces? ed 1 4 Yes 2	No 19097	Was Decedent of His If Yes, specify Cuban		Rican, etc.)	Black	k, White, etc	>.
21215-0036	ursaft ural", Il Exa	Completed by	3 Widowed 4 Divorced	If Yes, Give Year or Dates.	1971	1 ☐ Yes 2 🔀 No	Specify:		Specify:	white	<u> </u>
15-(72 hor "nat	uple	15. Decedent (Specify only highes		(Give	dent's Usual Occupa kind of work done du DO NOT use retired)	tion uring most of work	king	16b. Kind of Bu	siness/Indu	stry
212	vithin liene. sr tha the N	Sol	Elementary/Secondary (0-12) 12	College (1-4 or 8	D+)	borer			shee	t meta	al
pu	filed val Hyg	Be	17. Father's Name (First, Middle, La					ne (First, Middle, N			
ylaı	Ild be Ment narked natic e	으	Charles Edward	Mellott				Elizabe			
Maryland	e 1 and 2 should be filed within 7: of Health and Mental Hygiene. If item 27 is marked other than ir other traumatic event, the Me		19a. Informant's Name/Relationshi Leslie Merry		19b. Mail 22	ing Address (Street at 2 W. Fran	nd Number or Rur \mathtt{klin} \mathtt{St}	al Route Number, #1; Hage	City or Town, St ${ t rstown}$,	MD 2	de) 1740
Baltimore,	permit. Page 1 and 2 Department of Health Important: If item 2: any injury or other t		20a. Method of Disposition 1 Burial 2 Cremation 4 Donation 5 Other (Sp		20b. Place of Disp cemetery, cre	osition (Name of matory or other place	9)	Date	20c. Location -	City or Tow	n, State
Baltir	permit. P Departm Importar any injur		21. Sign va. o uneral Service I	censee	ector 2	2. Name and Address		ate Anat St; Bal			1201
-			23a. Part V. Enter the disease, or o	complications that cause	the death. Do not en						pproximate
y.	Ph_sician/		shock, or heart failure. List or Immediate Cause (Final disease or condition	nly one cause on each line	Lic/	iver c	inho	2.7			nterval Between Onset and Death
	Medical		resulting in death)	a. Due to (or as	a consequence of):	1000	11/1/4	()-			3 years
	Examiner	<u>.</u>	Sequentially list conditions,	b. —							
	sit sit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence of):						
	e be executed ysician and e burial-transit	Exal	that initiated events resulting in death) Last	c. Due to (or as	a consequence of):					+	
09	ate be e ohysicial the buri	dical		d							
876	tificat ing ph e as th	Мес	IF FEMALE:								
Box 687	ath cer	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 Live Birth 4 Pregnant a	2 Fetal death 3	Ectopic pregnancy Other (specify)	1		23d. Date Mon	e of delivery oth D	
_	he degy the g	hysid	1 Yes 2 No 9 Unknown	9 Unknown	at time of death 3 t						
P.O.	ss that the death certifica igned by the attending p be detached for use as	by P	Part II. Other significant condition	s contributing to death b	out not resulting in the	underlying cause give	en in Part I.	23e. Did tob	acco use contri	bute to the	cause of death?
ds,	requires been sig should b	ted						1 □ Y€	es 2 🗆 No	3 🗌 Probal	oly 4 Unknown
Records,	has has	Completed						24a. Was ar autops perforn 1 Yes 2	ned? pi	/ere autopsyrior to comp eath?	y findings available pletion of cause of
tal	ysician: The s certificate director, pag	Be	25. Was case referred to medical examiner?	Haspitali		1	ce of Death (Chec				
of Vital	Physi this c ral din	은	1 ☐ Yes 2 ☑ No 27. Manner of Death	Hospital: 1 Inpati 28a. Date of inju	ient 2 ER/Outpatie		_ 4 ☐ Nursing H	ome 5 Reside			
0 U	ding I th. After funer	cate	1 Natural 5 Pending 2 Accident Investig	(Month, Da	y, Year) 286. Time of injury	work?		28d. Describe ho	w injury occurre	d	
Division	Attending or death. ector: After by the fune	Certificate:	3 Suicide 6 Could n	ot be 28e. Place of Inj	ury - At home, farm, st			28f. Location (Str		r or Rural Re	oute Number,
Diγ	tal or A rs after al Direct led in by			building, et	c. (Specify)			City or Town	, State)		
	To the Hospital or Attending Phy within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral	Medical	(Check 2 Medical E	Physician: To the best of caminer: On the basis of e Nurse Practitioner: To th	examination and/or invest	stigation, in my opinior	n, death occurred a	at the time, date and	d place, and due	to the cause	e(s) and manner stated.
	To the within To the comp	2	29b. Signature and title of certifier		- Boot of the Mile Medige	29c. License		2	9d. Date signed	(Month, Da	y, Year)
)) (/o	m/2		136			Ebran	3,2	0/2
			30. Name and address of person w	ho completed cause, of colored	leath (Item 23a) (Type, $M.b.$ 92	Print) 4 Seton	Drive, (Cumberle	ard, m	02	1502
	Sta		31. Date filed (Month, Day, Year)		ar's Signature	ulal		-			
	Registr	ar	FFB 1 3 2	UIL Cerus	J G. 1994						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month William Marshall 6: 30.PM January 2012 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 1216 Glenville Rd. Churchville Harford Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Months Min Hours 219-44-8043 1 X M 2 D F 66 Фсt 11**,** 1945 Maryland Usual Residence of Deceden 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Harford Churchville 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1216 Glenville Rd. 21028 USA 11. Marital Status 12 Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces Black, White, etc. 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify. Specify: white 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) 12 claims adjuster Atena 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Robert Marshall Jr. Alyce Tehresa Leverton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1216 Glenville Rd; Churchville, MD 21028 Nancy Sostrin - sister 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 X Donation 5 Other (Specify) e of Funeral Se 22. Name and Address of Facility State Anatomy Board /Director 655 W. Baltimore St; Baltimore, MD 21201 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death End-Stage Dementia resulting in death) Due to (or as a consequence of)

Physician/ Medical Examiner

Physician/

Medical

Director

by Funeral

Completed

Be

မ

Examiner

Funeral

Director

show

ō

r 28a-f sh notified a

ıral", or items 23a or Examiner must be

"natural"

er than "natur , the Medical

the Maryland

permit. Page 1 and 2 should be filed within 72 hours after death with

and Mental Hygiene.

nt of Health and Mental Hyg I if item 27 is marked othe or other traumatic event,

Department of H Important: If ite any injury or ot

Baltimore, Maryland 21215-0036

Medical Certificate: To Be Completed by Physician/Medical Examiner b Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Property Property After this certificate has been signed by the attending physician and inding physician and use as the burial-transit signed by the attending physician d be detached for use as the buria To the Hospital or Attending Physi within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir

Division of Vital Records, P.O. Box 68760

Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of): C. Due to (or as a consequence of):		
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1		23d. Date of delivery Month Day Year
Part II. Other significant conditions of	ontributing to death but not resulting in the underlying cause given in Part I.	1 ☐ Yes 2	use contribute to the cause of death? No 3 Probably 4 Unknown 24b. Were autopsy findings available
25. Was case referred to medical	26. Place of Death (Chec	autopsy performed? 1 Yes 2 No	prior to completion of cause of death? 1 Yes 2 No
examiner?	Hospital; Other:		
27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident Investigatio.	28a. Date of injury 28b. Time of injury 28b. Time of injury 4 work? M 1 Year 1 Yes 2 No	ome 5 Residence 6 28d. Describe how injur	
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and City or Town, State)	d Number or Rural Route Number,)
(Check 2 L Medical Exam	sician: To the best of my knowledge, death occurred at the time, date and place, a iner: On the basis of examination and/or investigation, in my opinion, death occurred a se Practitioner: To the best of my knowledge, death occurred at the time, date and place.	t the time, date and place	, and due to the cause(s) and manner stated

29c. License number

00057465

203 Paltimore MD 21209 -

29d. Date signed (Month, Day, Year)

27/12

Registrar

State

29b. Signature and title of certifier

Ms Ryap MrlM. P.

FEB 1 3 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N-S (A)APAKY/NID 2835 SMIN AV 5

egistrar's Signatur

me redith. Jeannette

			State of	of Marylan						_		egibic.		
			For State Registrar		•	tificate					leg. No. 2	012	0395	CI
	Physicia	n/	1. Decedent's Name (First, Middle, Last)						2.	Date of Deat Month	Day	Year	3. Time of Death),
	Medic	al .	Jeannet 4a. Facility Name (if not institution, give street and nun		ine 1	Mered:		Location of	of Death	2_		aola inty of Death	13:131	IVI
	Examin		Franklin square Ho		1			lale	or Death			.14 i m	ore	
22 1	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. la	ast birthday)	If Under Months		If Under Hours		Date of Birth (Month, Day,	1		lace (State or Fore	ign
	Director		217-38-3790 1 ☐ M 💥 F Usual Residence of Decedent	69	Yrs.		,			ily 5,			yland	
	and show l at	jo.	10a. State 10b. County	10c, City	y, Town or Lo	cation						1	0d. Inside City Lim	
	Maryl 28a-f otifiec	irect	MD Baltimore			Di	unda	lk					1 🗌 Yes 2 🕇	No
	th the 3a or t be n	ral D	10e. Street and Number 7943 Charlesmont Ro	bec		10f. Zip		1222			_	of What Cour ted Sta		
	eath w	Funeral Director	11 Marital Status 12. Was Deco	edent Ever in U.S	6. 13.	Was Deced			igin? (Specify	Yes or No-		Race - Americ		_
98	fter de ', or it amine	þ	If Vac Civ	rces? 2 💆 No		lf Yes, spec 1 □ Yes				an, etc.)	Spec	Black, White, o		
21215-0036	ours a atural' sal Ex	Completed	3 Widowed 4 □ Divorced Year or D 15. Decedent's Education			dent's Usua				Т		of Business/Inc	nite	
215	n 72 h e. an "na Medio	ldm	(Specify only highest grade completed Elementary/Secondary (0-12) College (1		(Give	kind of wor O NOT use	k done a	luring mosi	at of working				,	
21	l withii ygiene her th t, the	Be Co	12 Years	,]	Recep	tion						ommunity	
Maryland	oe filec intal H ked ot c even	To B	17. Father's Name (First, Middle, Last) John Morris, Sr.							irst, Middle, M te Col		ame)		
ary	hould ind Me s marl umati		19a. Informant's Name/Relationship (Type, Print)		19b. Majli	ng Address	(Street a	and Numbe	er or Rural Ro	oute Number,	City or Tow	n, State, Zip (Code)	П
Σ	nd 2 s ealth a m 27 i		Lisa Edenton (Daughter)					mont		Dunda	TK, 140	arytand	2 2 1 2 2 2	
nore	ge 1 a nt of H t: If ite		20a. Method of Disposition 1 ☐ Burial 2 🏿 Cremation 3 ☐ Removal from		Place of Dispo emetery, crei Lltop	maton/or o	ther place	e) orp 2	Date 2/8/20			on - City or To on , Mai		
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show apprintury or other traumatic event, the Medical Examiner must be notified at once.		4 Donation 5 Other (Specify) 21. Signature of Funeral Service Lice see)								lk, Inc		_
ñ	permit Depar Impor any in		Drech EV		1/9	122 W	ise	Ave	Duna	ark, M	arylar	$\frac{1k}{nd}$, $\frac{1}{2}$	222	_
			23a. Part 1. Enter the disease or complications that shock, or heart sillere. List only one cause on earths.	caused the death ach line.		-				espiratory arre	est,		Approximate Interval Between Onset and Death	
	h sician/ Medical		Immediate Cause (Final disease or condition resulting in death)	mono (or as a consequ	L Y	Em	60	1,5	m					
7	Examiner			(or as a consequ	derices i).									
	_ #	iner	cause. Enter Underlying	(or as a consequ	uence of):									
	be executed sician and burial-transi	Examiner	Cause (Disease or injury that initiated events C.	(or as a consequ	uence of):						-			
0	be executed sician and burial-transit	g	d.		,									
9289	tificate ng phy as the	Med	IF FEMALE:											- 1
9 x	eath certificate b attending physi	ian/	23b. Was decedent pregnant 23c. If yes, ou	tcome of pregna Birth 2 Feta gnant at time of c	aldeath 3	Ectopic		у			23d.	Date of delive	ery Day Year	
Box	nat the dea ed by the a detached	Completed by Physician/Med	1 Yes 2 No 4 Preg 9 Unknown 9 Unk		Jean 3 L		Jecny/							
P.0	es that the	by P	Part II. Other significant conditions contributing to		_								ne cause of death?	
rds,	requires been sig should b	ted	3/P Pneumonect	,	Lun	9 0	41	cer					bably 4 Unkno	
Records,	has b	mple	morbid Obesit			-				24a. Was a autop perfor		prior to co death?	psy findings availal impletion of cause	of
Ä	n: The ificate or, pag		Chronic Renal =	Ensur	FICI	enc	76 PI	ace of Dea	ath (Check or	1 Yes	2 No	1 Yes	2 No	_
Vita	lysicia is cert direct	To Be	examiner? 1 Yes 2 No Hospital:	Inpatient 2 🗆	ER/Outpatie	nt 3 🗆 D	Othe	ar.			ence 6 🗆	Other (Specif)	<i>'</i>)	
Division of Vital	ing Ph		27. Manner of Death 1 Natural 5 Pending 28a. Date (Mon	of injury oth, Day, Year)	28b. Time o injury	ľ	8c. Injun	?		d. Describe h	ow injury oc	curred		
sior	Attend death ctor: /	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	e of Injury - At ho	ome, farm, str	M reet, factor		Yes 2		f. Location (S	treet and Nu	ımber or Rura	l Route Number,	
Divi	tal or after al Dire	Ce	4 - Horricide determined build	ling, etc. (Specify	")					City or Tow	n, State)			
	To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the	Medical	29a. Certifier (Check 2 Medical Examiner: On the bar	sis of examination	n and/or inves	stigation, in	my opinio	on, death o	occurred at the	e time, date a	nd place, and	d due to the ca	use(s) and manner s	stated
	To the vithin of the comple	Ž	only one) 3 Certifying Nurse Practitione 29b. Signature and title of certifier	r: to the best of r	ny knowledge			ne time, da e number	ate and place			gned (Month,		
			Thum M.	D			0	05	369	4	2/	3/11		
11	OV		30. Name and address of person who completed cau							U . U245			. 0	7
	Sta	te	31. Date filed (Month, Day, Year) 3.1.	Registrar's Signa	Pe L	ank l	n 5	quar	e Dri	UC 39	Itim	ore, m	V did	_/
	Registr		FEB 1 3 2012 Qu	was f	7. 19º	767								
					4									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 03956 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 815 Nadine A M Nelson 5 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore ity The Johns Hopkins Hospital 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Director 216-62-2994 55 Yrs 1 □ M 2 🗓 F Usual Residence of Decedent 20. Maryland r 28a-f show notified at with the Maryland 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Somerset Marion Station ò 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? iral", or items 23a or Examiner must be Funeral 21838 USA 29885 Hudson Corner Rd. 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 XNo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc þ 1 Never Married 2 XMarried 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 🕅 No Specify: "natural", 3 Widowed 4 Divorced Specify: Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry unk (Specify only highest grade completed) 2 should be filed within 72.1. th and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4 or 5+) 12 0 security Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Raymond Joseph Coombs Jr. Margaret Theresa Schoenfeldt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once, Terry F. Nelson - husband 29885 Hudson Corner Rd; Marion Station, MD 21838 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ∑ Donation 5 ☐ Other (Specify) 21. Sign Jura T Funeral Sen 22. Name and Address of FacilityState Anatomy Board Director 655 W. Batimore St; Baltimore, MD 21201 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death or heart failure. List only one cause on each line. Cause (Final Immediate Cause (Final Ph_sician/ disease or condition resulting in death) MOUDE Medical Que to (or as a consequence of) **Examiner** LUM EU . O Sequentially list conditions, Examiner Due to for as a consciousnes of: cause. Enter Underlying Cause (Disease or injury attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Day Month Year Pregnant at time of death a Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No 1 Yes 2 No To the Hospital or Attending Physician; Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 ☐ Yes 2 ☑ No Hospital Other: ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death Date of injury 28b. Time of 28c. Injury at work? within 24 hours after death.

To the Funeral Director: After the Funeral Director. 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending injury 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

State Registrar 29b. Signat

FEB

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SCHECHTER

600 North

Registrar's Signatu

Res- 000

Wolke Street Bultimore

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** /Medical a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Johns Hopkins Bayview Medical Center Baltimore If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 □X Director 85 8/1/1926 <u> 201–16–7317</u> Maryland Usual Residence of Decedent be filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County "natural", or items 23a or 28a-f show edical Examiner must be notified at 1 ☐ Yes 🏖 No Directo Maryland Baltimore Essex 10f. Zip-Code 10g. Citizen of What Country? 10e, Street and Number 235 Orville Road Funeral 21221 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ▼No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 X Married Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 XNo Specify. þ Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) traumatic event, the Medical (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. College (1-4 or 5+) Baltimore County Elementary/Secondary (0-12) 4 School System Nurse 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) it of Health and Mental H If Item 27 Is marked oth or other traumatic event Be William Worthington Alexander Pages 1 and 2 should ပ္ <u>Helen Lamm</u> 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 235 Orville Road Essex, Maryland 21221
of Disposition (Name of Date 20c. Location - City or Town, State Thomas John Nida (Husband) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages Department of Important: If II any Injury or once, 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 2614 4 ☐ Donation 5 ☐ Other (Specify) Sacred Heart of Jesus Cem. Dundalk, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bruzdzinski Funeral Home PA 1407 Old Fastern Avenue Essex, Maryland 21221 Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one gause on each line. hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner The law requires that the death certificate be executed attending physician and I for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 Yes 2 No Month Year be detached 9 Unknows signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 2 No 3 Probably 4 Unknown 1 Tes Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate has 2 No 1 Tyes within 24 hours after death.

To the Funeral Director; After this certifica completely filled in by the funeral director, I or Attending Physician; 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 Manner of eath 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury 28c. Injury at Work? Certification: Month, Day Natural 2 Accident Natural 5 Pending investigation М 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 I Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Hospital

State Registrar

11595

31. Date filed (Month, Day, Year) 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c License number

DD 000

29d Date signed (Month, Day, Year)

4940 Eastern Avenue, Baltimore, MD, 21224

DHMH 17 Rev 1/2001

29a. Certifier

(check only one)

29b. Signature and title of certifier

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		-	For Amend I	State of tem 23a pe	Marylandr.,	d / Depa g924-0	artment	of H	ealth a	nd Me	ntal Hyg	giene Reg. No	201	2	03958
	Division		1. Decedent's Name (First, Middle,			1 .				2	. Date of Dea		y Yea	r I	3. Time of Death
	Physici /Medio		1 homas		2000	SKI	Sr.				brucer		<u> </u>	2	8:51PM
	Examin		4a. Facility Name (If not institution,			_			Location of	Death		40.	County of De	ath	
		_	Johns Hopkins Bay 5. Social Security Number		7. Age (In yrs. I		Baltin if Under		If Under 2	24 Hrs. 8	. Date of Birth	h	9. E	irthpla	ce (State or Foreign
	Funeral Director		220-88-9517	1 X M 2□F	4		Months	Days	Hours	Min.	(Month, Day	(, Year)		ountry	and
			Usual Residence of Decedent		1400"	Ŧ								10	d. Inside City Limits
	arylar shov d at	<u>ا</u>	10a. State 10b. County Maryland N/A	١	10c. City	y, Town or Lo Balti								100	1 XYes 2 □ No
	the M 28a-f otlfie	rect	Maryland N/A	4		Daiti	10f. Zip-	Code				10a. Citi	zen of What (Country	
	3a or	Funeral Director	922 S. Clinton S	Street			101. 2.10	0040	2122	4		rog. o	USA		,
	death	nera	11. Marital Status	12. Was Deced	lent Ever in U.S	S. 13. \	Was Deced	ent of His	spanic Orig	in? (Specif	y Yes or No- can, etc.)		14. Race - An Black, Wh		
98	after or ite		1 Never Married 2 Marrie	If Yes, Give			1 Yes 2		Specify:	T delle Tile	ari, etc.)	1	Specify: W		
Ö	hours ural",	ed by	3 Widowed 4 Divorced 15. Decedent'	Year or Date	es:	16a Decer	dent's Usua	l Occurs	ation			16b K	ind of Busine		
7.	in 72 1 "nat ledlos	Completed	(Specify only highest	grade completed)	0.51)	, (Give	kind of wor DO NOT use	k done d	luring most	of working	Î	100.11	aria or Baonio	30,1114	,
212	with giene. r than	m o	Elementary/Secondary (0-12) 10 years	College (1-4	or 5+)	Su	pervi	sor					Toyota		
P	al Hyg I othe	Be C	17. Father's Name (First, Middle, La	-							First, Middle,		,		
ylaı	ould by Ments arked	၉	Nicholas Olszev			T					lieczoi				
Mar	12 sh nand 7 Isma raum		19a. Informant's Name/Relationsh Jacqueline Olsze		vife	1							or Town, State Maryl		
e,	1 and Healtl em 27	Ī	20a. Method of Disposition	244715T 44	20b. P	Place of Dispo	sition (Nam	ne of					ocation - City		
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp		ate c	emetery, crer yview	natory or ot	her place		ebrua , 201			•		ryland
alti	mit. F partme oortan Injur		21. Signature of Funeral Service Li			-		_					alk,P.		
ñ	any Der		I Janua Kall	shyh		7	110 S	olle	rs Po	int F	Road, I	Dund	alk,MD	. <u>2</u>	1222
			23a. Part 1. Enter the disease, or c shock, or heart failure. List or	omplications that can nly one cause on eac	used the death	n. Do not ent	er the mod	e of dying	g, such as o	cardiac or	respiratory ar	rrest,	2		Approximate nterval Between
	Physician		Immediate Cause (Final disease or condition	_a Re	5 Pit 6	Hory	Fer			LINOLIG	-,				Onset and Death
	/Medical Examiner		resulting in death)	Due to (o	r as a consequ	uence of).	Г	-	1.0						1 Acres C
		<u>ē</u>	Sequentially list conditions, if any, leading to immediate		oss or as a consequ	ナーウィム uence of):	ain F	UNC	170n					+ '	Ladays Ladays
	uted ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	C. C.	ardia	L A	rres	5+							6 days
Ć,	ate be executed hysician and the burial-transit	ш	resulting in death) Last	Due to (o	r as a consequ	uence of):									y
760,	ate be nysicia	dical	2	d										-	
Box 68	death certificat attending phy d for use as th	Physician/Me	IF FEMALE:	23c. If yes, outc	ome of preama	ancy.							004 D-1	4 - 15	
ĝ.	eath cattend	cian	23b. Was decedent pregnant in the past 12 months?	1 🗌 Live bir	rth 2 ☐ Feta ant at time of de	l death 3	☐ Ectopic p		,				23d. Date of Month		y Day Year
P.O.	the de / the a	hysi	1 Yes 2 No 9 Unknown	9 🗌 Unkno			3 o (·) · .								
	v requires that the de been signed by the a should be detached	by P	Part il. Other significant condition	ns contributing to dea	ath but not res	sulting in the u	underlying o	cause giv	en in Part i		23e, Did to	obacco	use contribute	to the	e cause of death?
rds	quires in sign									_	1 🗆 \	es 2	□ No 3 □	Proba	bly 4 Monknown
9	law requisible been 2 shou	Completed									24a. Was a autop	SV	24b. Were prior	autop	sy findings available opletion of cause of
<u>=</u>	The law ate has b page 2	Con									1 🗌 Yes	rmed? 2 No	death		2 □ No
Vita	yslcian: The sertificate director, pa	Be	25. Was case referred to medical examiner?	Hospital:				Othe			Check only or				
0	Physl this c ral dir	6	1 ☐ Yes 2 ☑ No 27. Manner of Death	1 139711		ER/Outpatien		^	4 🗆 Nur		d. Describe h		6 Other (S)	pecify)	
A sion	ding th. After fune	ţi İğ	1 Natural 5 ☐ Pending 2 ☐ Accident investig	28a. Date of (Month ation	, Day Year)	Injury	М	8c. Injury Work 1 □ \	? Yes 2 ☐ N	10					
$\lambda \beta \beta - \ell \ell$ Division of Vital Records,	I or Attending Physafter death. Director: After this din by the funeral d	Certification:	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determin	200. Flace	of injury - At ho g, etc. (Specify	ome, farm, str	eet, factory,	office		28	f. Location (S			Rural	Route Number,
40	ital or irs afte al Dir led in	Cer								4					
#	To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending ph completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the complete of the funeral director.	Medical		Physician: To the bearing: On the base	sis of examinat										
	the ithin 2 the orthodorum	Med	29b. Signature and title of certifier	and mann	er stated.		29c.	. License	number			29d. Da	te signed (Mo	nth, D	ay, Year)
	(8) E 3 E 8		Mul		0			Re	5	000		Toh.	many 3	3	2012
			30. Name and address of person v	vho completed cause	e of death (Iter	n 23a) (Type,	Print)			*	'				
				SATU M.		turo.			494	40 Eas	stern Av	/enu	e, Baltin	nore	e, MD, 21224
	Sta Registi	ILC.	31. Date filed (Month, Day, Year) FEB 1 3 201		gistrar's Signat	bark									
			, ED % O CO!	- Ceruch	1 10.	your									

DHMH 17 Rev 1/2001 11595

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 238 PM UGLESBY Medical Facility Name (if not institution, give street and number **Examiner** Boltimore Washnaton Medical en BURNE TONE ACUNDEL -Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year, Birthplace (State or Foreign Country) **Funeral** Min 355-24-9452 82 1 □ M 2 🔀 F **Director** June 18, 1929 Mississippi Usual Residence of Deceden 28a-f show 10a. State Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 🛣 No Anne Arundel Odenton MD 10e. Street and Number 5 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 21113 USA 2523 Blue Water Blvd items hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc "natural", or þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 black 1 ☐ Yes 2 X No Specify. Specify Completed 3 Widowed 4 X Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Secondary (0-12) College (1-4 or 5+) the 12 secretary jewish temple Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Curtis Barby Angola Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Wilson - niece 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☑ Other (Specify) In State injury 22. Name and Address of Facility State Anatomy Board meral Service I any rector 655 W. Baltimore St; Baltimore, MD 21201 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death or heart failure. List only one cause on each line Immediate Cause (Final Ph_sician/ disease or condition resulting in death) Medical Due to (or as a con Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examine Due to for as a cui Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury as the burial-tran and that initiated events resulting in death) Last Due to (or as a con attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: use 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 - Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ ō in the past 12 months? 1 Yes 2 No Month Day Year Pregnant at time of death signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ should be 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy nerforme within 24 hours after death. To the Funeral Director: After this certificate funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Hospital Other: 1 Inpatient ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined

Medical

29a. Certifier

31. Date filed (Month, Day, Year)

DHMH 17 Rev 06-2011

State Registrar

completed cause of death (Item 23a) (Type, Print)

GHEN BURNIE

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29d. Date signed (Month, Day, Year)

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate

		Plea amend	se Typ	e or Pri 12,162 ate of M	i nt in l larylah	Black II 18&19a d / Depa	ndelil &b P artme	ole Inler Al	k. Ens VA BD lealth	G92 and T	All Cor Mental	pies A 9/20 Hygie	re Leg 12 JH	gible.	
	State Registrar 1. Decedent's Name	(First, Middle	, Last)			Cei	tifica	te of L	Death		2. Date of		Some	0 1 2	2 0 3 9 5 1 3. Time of Death
an/ cal ner	Esau Pr 4a. Facility Name (if r		. aive street a	nd number)			4b Cit	y, Town, or	r Location	of Death	Febru	ary	Day 3	2012	3:05 Aм
	Washing 5. Social Security Nu	ton Ad		st Hos		ast birthday)	7	akom	a Pai		8. Date o	4 Disth		itgom	ery
	125-24- Usual Residence of I	7462	1 X M 2	□F /. Ag	79	Yrs.	Months		Hours	Min.	March March		1932		hplace (State or Foreign
Director	10a. State MD	10b. County	nce Ge	orges	1	y, Town or Lo		2							10d. Inside City Limits 1 ☐ Yes 2 → No
Funeral Dir	10e. Street and Number 7622 La	ber					10f. Z	ip Code 20782					. Citizen of	What Co	
2	11. Marital Status 1XX Never Marrie 3 Widowed 4	ed 2 🗆 Mari	ried 1 [as Decedent ned Forces? Yes 2 X 'es, Give ar or Dates.		I	f Yes, sp	edent of Hi ecify Cuba 2 No	in, Mexica	n, Puerto	ecify Yes or Rican, etc.	No-)		ack, White	
Completed	Elementary/Secon	ify only highenday (0-12)		llege (1-4 or	5+)		dent's Us kind of w O NOT u able	se retired)	ation during mo	k st of work	king		o. Kind of E		ndustry unk
To Be	17. Father's Name (Fi										ne (First, Mic			^{ne)} unk	.
	19a. Informant's Nar Floren Washing	ne/Relationsh	hard—	sister st Hoe	pital	19b. Maili 76	pg^ddpe 30 C	Street arrol		ctor e Ho	1115 AKOMA		11er 1423 , M	State Zio -1833 -2051	Code)
	20a. Method of Dispo 1 Burial 2 4 Donation	Cremation			, ce	lace of Dispo emetery, cren	natory`or	other plac			Date			·	Town, State
	21. Signature	eral Service L Ona I d	icensee S	El Di	recto	r 22					te An St;				21201
12	23a. Part Int the shock, of leart Immediate Cause (Fi disease or condition results or condition)	failure. List o inal	complication nly one cause	s that cause e on each lin	d the death	n. Do not ente	er the mo	de of dying	g, such as	s cardiac	or respirato	ry arrest,			Approximate Interval Between Onset and Death
ı	resulting in death) Sequentially list con-	ditions,	b. —	Due to (or as	cut	ev	ch	al-	fai	lw	e		· -		
ıl Examiner	if any, leading to impose cause. Enter Underly Cause (Disease or in that initiated events resulting in death) La	nediate ying njury	с	Oue to (or as		,									
Nedica			d												
Physician/Medical	IF FEMALE: 23b. Was decedent p in the past 12 m 1 ☐ Yes 2 ☐ 9 ☐ Unknown	onths?	1 4 5	es, outcome Live Birth Pregnant a Unknown	2 Fetal	Ideath 3	Ectopic Other (s	pregnanc	У					ate of deli	very Day Year
2	Part II. Other signific	cant condition	ns contributi	ng to death b	out not resu	ulting in the u	nderlying	cause giv	en in Part	: 1.				_	the cause of death?
Completed												Vas an autopsy performed Yes 2	?	prior to co death?	opsy findings available ompletion of cause of
To Be	25. Was case referred examiner? 1 ☐ Yes 2 ☐		Hospital	: 1 \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	ient 2 🗆 I	ER/Outpatien	+ 3 \Box r	Othe	er:		k only one) ome 5 \square F	Panidanaa	. e □ 0#	nor /C nonii	6.1
Certificate: T	27. Manner of Death 1 Natural 2 Accident	5 Pendin	g	. Date of inju (Month, Da	iry	28b. Time of injury		28c. Injury work	at at		28d. Descr				97)
	3 ☐ Suicide 4 ☐ Homicide	6 L Could i		. Place of Injubul		me, farm, stre	et, facto	ry, office				on (Street Town, St		per or Rura	al Route Number,
Medical	29a. Certifier 1 (Check 2 Conly one) 3 [_ Medical E	xaminer: On	the basis of e	xamination	edge, death o and/or invest knowledge, o	igation, ir	my opinio	n, death o	ccurred a	t the time, d	ate and pla	ace, and du	ue to the ca	ause(s) and manner stated
	29b. Signature and tit	e of certifier	, ~	n			1	c. License	number 6 ŏ	1:0		29d.	Date signe	ed (Month,	Day, Year) — (2
	30. Name and addres	U	norm		leath (Item			TA	mi Trus.	Spy	i /L	0 2	ME 0917	つ	-12
e ar	31. Date filed (Ment)	Bay Year	2012	32. Registra	ar's Signat	are diam	May								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Physician/ Mor MAN 1410 M 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Glen Burnie Anne Arundel Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country)unk Months Hours Min. (Month, Day, Ye Director 1945 240-68-151 Jan Usual Residence of Decedent Hygiene. other than "natural", or items 23a or 28a-f shov --* ***• Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Anne Arundel Annapolis 1 Yes 2 X No 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 900 Van Buren St. 21403 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc 1 Never Married 2 Married ş Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. black 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation unk 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 2 should be filed with h and Mental Hygien 7 is marked other th unk unk injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ permit. Page 1 and 2 should be Department of Health and Men-Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anne Arundel Medical Ctr. 2001 Medical Pkwy; Glen Burnie, MD 21401 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 🛛 Other (Specify) in state Signature of Properal Service Lic 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore St; Baltimore, MD 21201 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cau is neach line. Approximate Interval Between Onset and Death Immediate Cause (Final ESP Physician. IRMOR disease or condition Medical resulting in death) Examiner HILL if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of) sician and burial-trans Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Hospital or Attending Physician; The law requires that the death certificate be Box 68760 IF FEMALE yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 - Fetal death 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Year Pregnant at time of death detached P.O. ģ signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? و ک Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of page 2 s has autopsy performed' death? 1 Yes 2 No 1 Yes 2 No director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 2 No 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28c. Injury at Certificate: 28a. Date of injury 28b. Time of 28d. Describe how injury occurred After (Month, Day, Year) 1-Natural 5 Pending work within 24 hours after death
To the Funeral Director: A
completed filled in by the f 1 Yes 2 No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 012012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

449 DEFENSE

LATENTA

Year 3 in

32. Registrar's Signature

WNAPOLIS

			For	Please amend	Type or Pri item 8 pe State of M	int in Bla	ck Indelible I 27 5-31-12 Department of	nk. Ensure	All Copie	es Are	e Legib	le.	
			For State Registrar		014.0	idi yidi idi.	Certificate of		Wichital 1.	Reg. No		2	03962
и	Physicia	n/	1. Decedent's Name	(First, Middle, Las	,	20			2. Date of D	eath		ar	3. Time of Death
18 mg	Medi	al	4a. Facility Name (if n	E and institution give		DIC	ORD	, or Location of Deat	FEBRUA			『ス	9:58 PM
-	Examir	er	_		T HOSPI	ICE		ARD C	_				ARD
	Funeral		5. Social Security Nur	mber 6. Se		je (In yrs. last bir		ar If Under 24 Hrs	8. Date of B		. 9	. Birthpl Countr	lace (State or Foreign
	Director 3		Usual Residence of D	13/0		86	rrs.		NULY	7- 1°	125	M	(D
	he Maryland or 28a-f show notified at	ctor		10b. County		10c. City, Tow		> \				10	d. Inside City Limits
	with the Maryland 23a or 28a-f shoust be notified at	Dire	10e. Street and Numb	HOU	AND	ELL	1 C O T T			10a Ci	tizen of Wha	t Count	1 Yes 2 No
	ith with the ms 23a or must be i	Funeral Director	3709 N	NEADO	WUALE	ROA		1042		109.01	U, 5		•
	r items		11. Marital Status		12. Was Decedent Armed Forces?	Ever in U.S.	13. Was Decedent of		pecify Yes or No to Rican, etc.)	-	14. Race - A	America	ın Indian,
5-0036	s after ral", o Exam	ed by	1 ☐ Never Marrie 3 ★Widowed 4		1 Yes 2 X If Yes, Give Year or Dates.	, No	1 🗆 Yes 2 💢						HITE
5-0	'2 hours after "natural", or edical Exami	Completed	(Speci	15. Decedent's Edify only highest gra	ducation	16a	. Decedent's Usual Occ (Give kind of work don		rkina	16b. K	(ind of Busin		
2121	ithin 7 iene. r than the M	Com	Elementary/Secon		College (1-4 or 8	5+)	life. DO NOT use retire HOUSE	ed)	9	0	WN	H	$n \sim F$
	filed wall Hygard A othe	Be	17. Father's Name (Fin				11095		me (First, Middle			7/0	, , , , , , , , , , , , , , , , , , ,
Maryland	1 and 2 should be filed within 72 hours after dea of Health and Mental Hygiene, item 27 is marked other than "natural", or ite other traumatic event, the Medical Examiner.	욘	JULIE	5 F.	WISEM			TILLI					EISTER
Mai	12 shouth and 27 is not reaum		19a. Informant's Nam		pe, Print) 50N PEDD 1 CD	'''	D. Mailing Address (Street				Town, State	, Zip Co	ode) 77 CITY YLAND 21042
re,	e 1 and of Hea If item or other		20a. Method of Dispo	sition		20b. Place o	709 ME of Disposition (Name of		Dato	20c L	ocation - Cit	v or Tou	un State
Baltimore,	Page ment o tant: If ury or		1 ☐ Burial 2 🛎 4 ☐ Donation 5	Cremation 3 L 5 Cother (Specify	Removal from State	ARO	ry, crematory or other p CAEA 22. Name and Add	na sioni	13,202	H	ANO	vil	1,MD
Balt	permit. Page Department Important: I any injury or once.		21. Signature of Fune	eral Service Lice	1	L. CANO	I						
			26a. Bart ter the	e dise v., or con	LFO, ications that caused	the death. Do	not enter the mode of d				APEL		Approximate
	Physician/	1	sho k, or heart Immeriate Cause (Fi dise se or condition	failura Lis Mily of	ie cause on each line	9.	-	, ,	, ,,,,	,			Interval Between Onset and Death
	Medical Examiner	۱	re ulting in death)	•		BILI I a consequence	of):					+-	O WEEKS
		e l	Sequentially list cond if any, leading to imm		b. STR	OKE a consequence	oft.					- 2	3 YEARS
8	uted d ansit	Examiner	cause. Enter Underly Cause (Disease of first that initiated events	ring		a consequence	51).						
	e executed cian and urial-transit		resulting in death) La	st	Due to (or as	a consequence	of):						
68760	cate be physicia the bu	Physician/Medical			d							+	
89	ath certifica attending p for use as	Ž Į	IF FEMALE: 23b. Was decedent pr	egilarit	23c. If yes, outcome						23d. Date of	f deliver	v
Вох	death he atte ed for	sicie	in the past 12 mg	onths? No	4 Pregnant a		3 Ectopic pregna 5 Other (specify)				Month		Day Year
P.O.	that the dealed by the a		9 Unknown Part II. Other signific	ant conditions co		ut not resulting	in the underlying cause	given in Part I.	23e Did t	tobaccou	ise contribut	e to the	cause of death?
S, F	uires th signe Id be o	Completed by			LATTO								ably 4 🛮 Unknown
Records,	aw require as been s 2 should	plete		•					24a, Was		24b. Were	autops	sy findings available
Rec	The law cate has page 2:	ခြီ ပြ							auto perfo 1 🗆 Yes	ormed? 2 🗶 No	deat	to com h? Yes 2	pletion of cause of
/ital	iysician: The is certificate director, pag	m	25. Was case referred examiner? 1 Yes 2 2	1	Hospital:		In	Place of Death (Che					11000
of Vital	g Phy: er this neral di	e:	27. Manner of Death		28a. Date of injur	ry 28b. 1	Time of 28c. Inj	4 □ Nursing F ury at	lome 5 Resi 28d. Describe I			pecify)	HOSPICE
ion	Attending I r death. ctor: After y the funer	Certificate:	2 Accident	5 ☐ Pending Investigation 6 ☐ Could not be	(Month, Day	r, rear) I		ork? □ Yes 2 □ No					
Division	of or Attency after death Director:	Cert	4 Homicide	determined	28e. Place of Inju building, etc	ry - At home, fa . (Specify)	rm, street, factory, office	9	28f. Location (S City or Tox			Rural R	loute Number,
	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physic completed filled in by the funeral director, page 2 should be detached for use as the bu	Medical	29a. Certifier 1 2	Certifying Physi	ician: To the best of	my knowledge,	death occured at the tin	ne, date and place, a	and due to the ca	ause(s) an	id manner as	stated.	
	the H thin 24 the Fu mplete		only one) 3 ∟	Certifying Nurse	e Practioner: To the	kamination and/o	r investigation, in my opi edge, death occurred at	the time, date and pla	at the time, date a ace, and due to th	and place ne cause(s	, and due to to and manne	the caus r as state	e(s) and manner stated. ed.
	9 ≥ ≥ 6		29b. Signature and titl	e of certifier			29c. Licer	se number	-	29d. Dat	te signed (M	onth, Da	ıy, Year)
	10		30. Name and address	s of person who co	ompleted cause of de	eath (Item 23a) (Type, Print)	21373		126	KUIT	y !	13,2012 1MD 21044
			DANIE	UE DO	BERMAN	1, MB	6336	CEDAR	LANE	CO.	ume	3/7	MD 21044
	Stat Registra		FEB 1 3 2		32. Registra	r's-Signature	,						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ February 6,2012 8:39 P Poole Canda Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Linthicum Heights Hospice of the Chesapeake If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign cial Security Number 7. Age (In vrs. last birthday) **Funeral** 579-74-9263 Year! Director 1 🗆 M 2 🗶 F March 26, 1956 Washington DC 55 Usual Residence of Decede show 2 should be filed within 72 hours after death with the Maryland thit and Mental Hygiene.
27 is marked outer than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10c. City, Town or Location Director 1 Yes 2 X No Howard Maryland Jessup 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 20794 USA 7680 Race Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🗶 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married 1 Yes 2 If Yes, Give Year or Dates Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. White Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) e. DO NOT Elementary/Secondary (0-12) College (1-4 or 5+) Food Service Micro Imagining Be Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic 18. Mother's Name (First, Middle, Maiden Surname)
Norma F. Davenport 17. Father's Name (First, Middle, Last) Richard F. Larson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7680 Race Road, Jessup, Maryland 20794 John Poole, Sr.- Husband 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
Meadowridge Mem. Park 02/10/2012 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Elkridge, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Gary L. Kaufman F.H. @ MMP 22. Name and Address of Facility 21. Signature of Funeral Service Livensee MO1284 7250 Washington Blvd., Elkridge, Maryland 21075 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between nset and Death Immediate Cause (Final Physician 8 To se a disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to lor as a consequence of Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Dav Year signed by the at Id be detached for Pregnant at time of death
Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed s after death.

Director: After this certificate 2 No 1 Yes Yes 2 To the Hospital or Attending Physician: funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 D Other (Specify of O'ce How) 2 1 🗌 Inpatient 2 🗍 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injurÿ (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at Natural 5 Pending work? 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide filled in by the Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide determined within 24 hours a

To the Funeral C

completely filled Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Contifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature appriite of cortifie 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 06-2011

State

completed cause of death (Item 23a) (Type, Print)

32. Registrar's Sign

12-01074

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ill Kelly Peters		1- For State Registrar	tate of Maryla		artment o ertificate o		d Mental		Reg. No. 2	012 0396
Physici Medical Exam	an/	Decedent's Name (First, Mid- Jill Kelly Pe		3				2. Date of De Month February	Day Year	3. Time of Death 1416 hrs
ileuicai Exam		4a. Facility Name (if not instituti				4b. City, Town, or	Location of D		4c. County o	f Death
		Howard County Gene				Columbia			Howard	La Burni
Funeral Director		5. Social Security Number	6. Sex	7. Age (In yrs.		If Under 1 Year Months Day		Min	: 12,1967	9. Birthplace (State or Foreign Country) Maine
Director		049-60-5530 Usual Residence of Decedent	1 M 2 X F	4	4 Yrs	5.		August	. 12,1907	Country) Partie
A.		10a. State 10b. County	,	10c. City	, Town or Local	ion				10d. Inside City Limits
Maryland 28a-f show d at once,	ō	Maryland How	ard		Colu	mbia				1 Yes 2 No
e Mary	Director	10e. Street and Number 6648 Dasher Cou	v t-			10f. Zip Code	21045		10g. Citizen of Who	-
5-0036 de within 72 hours after death with the Maryland bygiene. other than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at once.		11. Marital Status		edent Ever in U		as Decedent of His	spanic Origin?		lo- 14. Race	- American Indian, Black,
death v r item	Funeral	1 Never Married 2 X	Married Armed Fo	2 X No	lf Y	es, specify Cubar	n, Mexican, Pu	erto Rican, etc.)	White	
s after ral", o	b		ivorced If Yes, Give Yee or Dates:		1	Yes 2 X No		Lof work done	Specify: 16b. Kind of Bus	White
)36 hin 72 hour te. than "natu	ted	 Decedent's Education (Sp Elementary/Secondary (0-12 				nost of working life			TOD. KING OF BUS	siries s/iridusit y
036 ithin 7 ne.	Completed		4+		National	L Director				rance
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be Co	17. Father's Name (First, Middle John Kinsley Pet							, Maiden Surname) Ann Brouilla	
IOFE, MD 21215 ges 1 and 2 should be file ges 1 and 2 should be file i: If item 27 is marked by other traumatic event, til	ם	19a. Informant's Name/Relation Scott Rivers	iship (Type, Print) (Husba	and)	48.4	g Address (Stree Dasher Cour	_		umber, City or Town	
imore, MD 2 Pages 1 and 2 shoul nent of Health and N ant: If item 27 is n or other traumatic		20a. Method of Disposition			Place of Dispos	sition (Name of ce	metery,	Date	20c. Location -	City or Town, State
MOF Pages tent of int: If		1 X Burial 2 Cremation 4 Donation 5 Other			. John Ce			2-10-2012	Ellicott	City, Maryland
Baltimore, permit. Pages I an Department of Hea Important: If itel iojury or other tr		21. Signature of Funeral Service	e Licensee	34	5	Name and Address 555 Twin Ki	nolls Ro	ad Colum	neral Homes bis, Maryla	nd 21045
Physician		23a. Part I. Enter the disease, of failure. List only one caus	or complications that complete on each line. Fen	aused the deat	h. Do not enter i	the mode of dying,	such as cardi Pheno	ac or respiratory a	rrest, shock, or hea	Between Onset and
IV edical Examiner	4 8	Immediate Cause (Final diseas or condition resulting in death)	e a. Diphenh Due to (or as a			Prometha	zine Us	se		Death
		Sequentially list conditions,	b	Contocquonico						
	iner	if any, leading to immediate cause. Enter Underlying Caus		consequence	of).					
uted d ansit	Examine	(Disease or injury that initiated events resulting in death) Last		consequence	of):					
O, the executed sician and burial - transit	dical	X UNPENDED	AMENDED 2	3a,27,	28a-f,p	er me,g92	26 4-12	2-12 sm		
68760 certificate b nding physise as the bu	/Me	IF FEMALE: 23b. Was decedent pregnant in		outcome of pre		etal death 3	Ectopic pro	egnancy	23d. Date of o	delivery Day Year
eath certification and as the	iciar	past 12 months?	4 Pregn	ant at time of d		ther (Specify)		ognanoy		22,
BOX (he death of the attention hed for us	Physician/M	1 Yes 2 ✓ No 9 U	nknown 9 Unkno		resulting in the	underlying cause	given in Part I	23e Did	tobacco use contrit	bute to the cause of death?
Division of Vital Records, P.O. rate of arteoling Physician: The law requires that the start death. 1 Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach	δ	Part II. Other significant cond	contributing to	death but not	resulting in the	underlying cause	giveri iiri diri.			Probably 4 Unknown
ords, P w requires t is been signs should be c	Completed							24a. Wa		Vere autopsy findings available rior to completion of cause of
ecol he law tte has	ld mc	-			<u> </u>			— per	formed? d	eath? Yes 2 No
Vital Rec ysician: The his certificate director, page	ပို	25. Was case referred to medic examiner?				26.Place	e of Death (Ch	eck only one)		
F Vit Physici or this c	To B	1 ✓ Yes 2 No			ER/Outpatien 28b. Time of		Other ₄ N		Residence 6	
on of Noding Ph. h. : After tl	흥	27. Manner of Death 1 Natural 5 Pe	ndina	, Day Year)		1 1	Yes 2. K⊠ No		t took dr	
IVISIOF or Atteod after death Director:	licat	2 X Accident Inv	estigation fd 2	-5-12 e of Injury - At	home, farm, stre	et, lactory, office l	building, etc.	28f. Location	(Street and Number	er or Rural Route Number, City
Div pital o ours aff	Certification:	4 Homicide	termined (Specify)	Resid				Columb	oia,MD.	Dasher Ct.
Division of Vital Records, P.O. Box 6876C To the Hospital or Atteoding Physician: The law requires that the death certificate within 24 buors after death. To the Fuberral Director. After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the b	ledical (29a. Certifier 1 Certifying one) 2 Medical Ex	Physician: To the best	st of my knowle	dge, death occu	irred at the time, d	ate and place,	and due to the ca red at the time, dat	use(s) and manner te and place, and di	as stated. ue to the cause(s)
To the To the Comp	Medi	29b Signature and title of certi	and manner s	tated.	. 0	29c. Licens				ed (Month, Day, Year)
		Tuto 2%	165/		2000	O.C.	M.E.		February 7,	, 2012
		30. Name and address of person								
		Victor Weedn MD JE	1.0			V. Baltimore S	Street, Balt	imore, MD 21	223	
Regis	tate			egistrar's Signa	ture					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician/ - Month February JP Russell Roberts, III Medical 4a. Facility Name (if not institution, give street and number **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Hospitalot B- Itimore N/A 8. Date of Birth October 11, 1958 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 218-82-3133 North Carolina 53 Director 1 🛛 M 2 🗆 F 28a-f shov 10b. County items 23a or 28a-f shoner must be notified at 10a. State 10c. City, Town or Location Director 10d. Inside City Limits Maryland N/A Baltimore 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2525 West Belvedere Avenue 21215 USA 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. ō þ 1XX Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 nan "natural", o Medical Exam 1 ☐ Yes 2 X No Specify: White 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) should be filed within 72., and Mental Hygiene.
7 is marked other than "n Elementary/Secondary (0-12) College (1-4 or 5+) other traumatic event, the Disabled N/A Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည JP Russell Roberts, Jr. Leona Jackson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other traunonce. Carol Roberts/stepmother 2505 Wendover Road Parkville MD 21234 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2/14/12 Parkwood Cemetery Baltimore MD 22 Name and Address of Facility Leonard J. Ruck, Inc. 5305 Harford Road Baltimore MD 21. Signature of Funeral Service License 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physicist/ disease or condition resulting in death) Medical Examiner Sequentially list conditions Examine cause. Enter Underlying Cause (Disease or injury and that initiated events resulting in death) Last physician a the burial-Physician/Medical law requires that the death certificate be P.O. Box 68760 as IF FEMALE: nse 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Month Day Year Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Syndrome, Parkinson's Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Aramia has performe this certificate Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 🗆 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this funeral of 27. Manner of Death 28c. Injury at work? 28a. Date of injury 28b. Time of 28d. Describe how injury occurred 1 Natural (Month, Day, Year) within 24 hours after death.

To the Funeral Director: Aft 5 Pending 1 Tes 2 No 2 Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Khosravi 31. Date filed (Month, Day, Year, 32. Registrar's Signature State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 20T2 Kharka February 9:45p M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 5000 Goodnow Road Apt. N/A Baltimore If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthdav) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Davs 216-81-6316 **Director** 46 9-1-1965 Bhutan Usual Residence of Decedent 28a-f show other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD N/A 1 Yes 2 No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5000 Goodnow Road Apt L 21206 Bhutan Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black. White, etc. by 1 Never Married 2 X Married 1 ☐ Yes 2 🛣 No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: Asian Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) (UNK) (UNK) 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ganja Singh Rai Phul Maya Rai 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dil Rai - Wife 5000 Goodnow Rd. Apt. L Baltimore, MD 21206 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place, 4 Donation 5 Other (Specify) Oak Lawn Cemetery 2-13-2012 Baltimore, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Kaczorowski Funeral Home, PA 1201 Dundalk Avenue Baltimore, MD 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ 08 ancel disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 1 Yes 2 No Be (25. Was case referred to medica examiner? 26. Place of Death (Check only one) Hospital Other: ၉ 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 Inpatient 2 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pendina 1 Yes 2 No Investigation 3 Suicide 4 Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

State Registrar

MH 17 Rev 06-2011

only one 29b. Signature/a

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HARLES

3 2012

W

6701

 Λ_{i}

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

. Charles

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ tebanan Medical Name (if not institution, give street and number) City, Town, or Location of Death of Death **Examiner** 7. Age (In yrs. last birthday) 8 Date of Birth Birthplace (State or Foreign Country) **Funeral** Min (Month, Day, Vear 213-20-1157 Director 8 LOYIS. MARYLAND or 28a-f show 10d. Inside City Limits 10a, State 10c. City, Town or Location Examiner must be notified at Director BALTIMORE ROSEDALE MD 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 8109 EDWILL AVENUE 21237 U.S.A. items death 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 X Married ò Completed by 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify WHITE Specify: "natural" 3 Widowed 4 Divorced Year or Dates. WWII injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) than, College (1-4 or 5+) Elementary/Secondary (0-12) and Mental Hygiene. is marked other tha permit. Page 1 and 2 should be filed wit. Department of Health and Mental Hygier Important; If item 27 is marked any injury or other. 10 SUPERVISOR GENERAL MOTORS Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) SCHELLENSCHLAGER **EVA** CONSTANCE ပ MATHIAS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CECILIA SCHELL/WIFE 8109 EDWILL AVENUE ROSEDALE, MD 21237 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date 1 Surial 2 Cremation 3 Removal from State cemetery, crematory or other place 2-13-2012 BALTIMORE, MD OAKLAWN CEMETERY 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of FacilitCVACH/ROSEDALE FUNERAL HOME 21237 1211 CHESACO AVE ROSEDALE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Oronar disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examine cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of that initiated events Due to (or as a consequence of) resulting in death) Last burialphysician Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 the as t IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ for in the past 12 months?

1 Yes 2 No Year Month Day Pregnant at time of death Linknown 9 Unknown P.O. þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? has page 2 Yes 2 No certificate funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: the Funeral Director: After maletely filled in by the funer (Month, Day, Year) 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined hours after Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within To the 29b. Signature and title of certifier မ Name and address of person who complete cause of death (Item 23a) (Type, Print) Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ February 8, 2012 Dorothy Ellen Smith 10:52 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore 111 Roberts Avenue Catonsville If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, Year) Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 212-28-1752 1 □ M 2 👺 F **Director** 93 Yrs Feb. 5, 1919 Maryland Usual Residence of Decedent 28a-f show ms 23a or 28a-f shor must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State Director MD Baltimore Catonsville 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21228 Funeral 109 Roberts Avenue USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc ģ 1 Never Married 2 Married Yes 2 🔀 No Specify: Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. "natural", If Yes Give Completed 3 X Widowed 4 Divorced Shows h and Mental Hygiene.

27 is marked other than "natural" Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Social Security Admin Clerk 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ Louise Butler Henson Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trau 111 Roberts Avenue; Catonsville, MD 21228 Daughter Maxine Smith 20b. Place of Disposition (Name of cemetery, crematory or other place)
Arbutus Memorial Park 2/14/2012 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State Arbutus, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 21228 Signature of Funeral Service Licer He 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death myowohal intender Pass ble Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or injury that initiated events The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Pregnant at time of death P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner?
1 ☐ Yes 2 ☑ No Daughter's Other: 4 Nursing Home 5 Residence 6 Other (Specify) House 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After to ompletely filled in by the funer 1 🔀 Natural 5 Pending Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined

State Registrar 29a. Certifier

(Check

Signature

3

DHMH 17 Rev 06-2011

32. Registra s Sig

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Son who completed cause of death (Item 23a) (Type, Print)
South 45 Feller & Ref helica Ganalle 10 21238

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

12-00983 Robert Stolley

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

(obcit otollo)	B	- For State Critificate of Death Reg. No.
Physician	7	1. Decedent's Name (First, Middle, Last) Robert Stolley 2. Date of Death Month Day Year February 2, 2012 3. Time of Death 0948 hrs
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death St. Agnes Hospital 4c. County of Death Baltimore
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 Nov. 23, 1941 7. Age (In yrs. last birthday) 1 Nov. 23, 1941 7. Age (In yrs. last birthday) 1 Nov. 23, 1941
v any	-	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits
Maryland 28a-f show d at once.	<u> </u>	MD Baltimore Catonsville 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
eath with the Maryland items 23a or 28a-f sho ust be notified at once.		1910 Frederick Road 21228 USA
iter d		11. Marital Status 1
hours a	ea nà	15. Decedent's Education (Specify only highest grade completed) 15a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry
5-0036 Item 72 hours at tygene other than "natural the Medical Examin	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) 2 Landscaper Horticulture
21215-0036 uld be filed within 7 Mental Hygiene. Marked other than c event, the Medica		17. Father's Name (First, Middle, Last) Robert Harold Stolley 18. Mother's Name (First, Middle, Maiden Surname) Lillian Cannon
TOFE, MD 2121 gges I and 2 should be fi nto Fleath and Mental it: If item 27 is marked other traumatic event,		19a. Informant's Name/Relationship (Type, Print) Deborah McDonough Niece 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 320 Tyson Road; Schwenksville, PA 19473
Baltimore, permit. Pages I and Department of Healt Important: If iteal injury or other tran		20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify: 20b. Place of Disposition (Name of cemetery, crematory or other place) Garrison Forest 20c. Location - City or Town, State 2/24/2012 Owings Mills, MD
Balt permit Depart Import		21. Signature of Juneral Service Licensee 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 21228
Physician Vedical		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death
Examiner		or condition resulting in death) Due to (or as a consequence of):
		Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Class a consequence of):
uted d ansit	EXall	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): d.
760, cate be executed physician and he burial - transit	Medical	UNPENDED AMENDED
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Fuoreral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transition in the funeral director, page 2 should be detached for use as the burial - transition in the funeral director.	Physician/Me	IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 2 Unknown 2 Unknown 2 Unknown 2 Unknown 2 Unknown 2 Unknown 2 Unknown 2 Unknown 3 Unknown 4 Unknown 5 Unknown 5 Unknown
D. Bo; the deatl by the att		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?
S, P.(nires that signed d be det	9 0	Inguinal hernia 1 yes 2 No 3 Probably 4 ✓ Unknown
Division of Vital Records, P.O. as or Attending Physician: The law requires that the all Director: After this certificate has been signed by led in by the funeral director, page 2 should be detactived in the funeral director.	Completed	24a. Was an autopsy findings available autopsy performed? 1 ✓ Yes 2 No 1 ✓ Yes 2 No
tal Rection: The certificate ector, page	ᇎ	25. Was case referred to medical 26.Place of Death (Check only one)
1 of Viting Physical Lines I directly directly functed di	의	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other 1 Nursing Home 5 Residence 6 Other Scene 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred
ion (tending death.	ation	Natural 5 Pending 1 Yes 2 No
Divis Hospital or At 24 hours after d i Fuocral Direc	Certification:	3 Suicide 6 Could not be determined Could not be determined (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)
To the Hospital within 24 hours To the Fuocral completely filled	Medical	29a. Certifier (Check only one) 2 W Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
To vii	Ã.	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) February 3, 2012
	-	30. Name and address of person who completed cause of death (Item 23a)
Sta	to	Zabiullah Ali, M.D. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (Month, Day Year) 32. Registrant Signature
Registra	ar	31. Date filed (Month, Day Year) 32. Registrant Signature

			Plea	ase Type								-		_	ible.		
	•	State of Maryland / Department of Health and Mental Hygiene Certificate of Death Certificate of Death) 2	03	3970				
Dhysisis	n/	1. Decedent's Name	e (First, Middle	e, Last)								2. Date of De			Vanu	3. Time o	
Physicia Medic		KAYLA JEAN STEVE										Month O İ	3,	,	Year 20/2	18	40 M
Examin	er	4a. Facility Name (if	GROVI	-		7			ty, Town, or		of Death				of Death	ERY	
Funeral Director		5. Social Security Ni INFAN	6. Sex 1 ☐ M 2 🔀	7. Ag	je (In yrs. I	ast birthda Yrs	y) If Un Month	der 1 Year		Min 59	8. Date of Bir (Month, Da	rth ay, Year)	2012	Cour	olace (State of try)	_	
d t tow	_	Usual Residence of Decedent											I Od. Inside C				
larylar 3a-fsl ified	ecto	MD	Mon	tgomery			01ney							s 2 No			
th with the Maryland ms 23a or 28a-f show must be notified at	Funeral Director	10e. Street and Nun	nber			-	01110)		Zip Code				10g. Citizen of What Country?				
th with ms 23 must	ner	4824 Abbeyville Pl. 20832 USA															
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status1 X Never Marri3 □ Widowed		ried 1 1 1 If Yes	Forces?	Ever in U.S No	3. 1	If Yes, sp		n, Mexica	an, Puerto	pecify Yes or No- o Rican, etc.) 14. Race - Black, Specify:					
2 hour "natu	plet	(Spe		nt's Education est grade comple	eted)				sual Occup		st of worki	ina	16b. k	(ind of Bu	usiness In	dustry	
d within 7, ygiene. her than it, the Me	Be Completed	Elementary/Seco	onday (0-12) NT	Colleg	je (1-4 or NFANT		(Give kind of work done during most of working life. DO NOT use retired) INFANT							INFANT			
oe filec ntal H ced ot ever	To B	17. Father's Name (I		,								e (First, Middle,			e)		
ould bud Me		Perry Stevenson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street										Steve:			tate Zin (Codel	
nd 2 sh salth an n 27 is er trau		19a. Informant's Name/Relationship (Type, Print) Lisa R. Stevenson — mother 19b. Mailing Address (Street and Number or Rural Route Number, C 4824 Abbeyville Pl; Olney, M															
Page 1 ar ment of He ant: If iten ury or oth			☐ Cremation	3 □ Removal f		, 0		sposition (N rematory o	ame of r other plac	e)	I	Date	20c. L	ocation -	City or To	own, State	
permit. Depart Import any inj		21. Signature of Euneral Service Licensee 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore St; Baltimore, MD 21201															
		23a. Part 1. Inter the	he disea o, or	complications the	nat cause	d the deat	h. Do not e							no Lo,	1.5	Approxima	
Physician/ Medical		shock, of veart failure. List only one cause on each line. Immediate Caus. Final disease or condition resulting in death) EXTREME PREMATURITY Due to (or as a consequence of):															
Examiner	Jer	Sequentially list conditions, if any, leading to immediate b. RESPIRATORY DISTRESS SYNDROME										-					
ath certificate be executed attending physician and for use as the burial-transit	I Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that Initiated events resulting in death) Last Due to (or as a consequence oi). CONGENITAL MALFORMATIONS Due to (or as a consequence of):															
ate be ohysic the bu	dic			d											_		
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the but	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1								23c					d. Date of delivery Month Day Year		
es that th signed by be detac	Ď.	Part II. Other significant conditions contributing to death but not resulting in the underlying cause give									t I.	- 1		ntribute to the cause of death?			
requir been s should	letec											24a. Was		·		osy findings	
r: The law icate has r, page 2 :	Completed	05 W										auto perfo 1 🗆 Yes	psy ormed?	p		mpletion of o	
s certil	To Be	25. Was case referre examiner? 1 ☐ Yes 2 ☐	No medical	Hospital:	None		ED/Outpot	tiont 2 🗆	Tothe	Place of Death (Check only one)							
iding Phy th. After this funeral c		1 ☐ Yes 2 ☐ X No 1 ☐ X Inpatient 2 ☐ ER/C 27. Manner of Death 1 X Inpatient 2 ☐ ER/C 28a. Date of injury (Month, Day, Year) 28b. (Month, Day, Year)							28c. Injury work	at	_ :	Home 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred					·
al or Atter s after dea il Director ed in by the	Certificate:	3 Suicide 4 Homicide	6 Could determ	not be 28e. Pl		ury - At ho c. (Specify		street, fact	ory, office		28f. Location (Street and Number or Rural Route Number, City or Town, State)					ber,	
he Hospit in 24 hour he Funera pleted fills	Medical	(Check 2	Medical E	Physician: To the xaminer: On the Nume Praction	basis of e	xamination	and/or inv	estigation,	n my opinic	n, death c	occurred at	the time, date a	and place	, and due	to the car	use(s) and ma	anner stated.
Tot with Tot		29b. Signature and	title of certifier	ashiri	NEO	JATA	10915		9c. License	number 670	20				(Month, I		
'	- 2	30. Name and addre		who completed o		eath (Item	23a) (Type	e, Print)						•			
Stat	e	NADEE M 31. Date filed (Month		SHMI	MD Registr				IL CE	NTEI	e DR	IVE RC	DCKV	ILLE	= M	ARYLA	AND
Registra	ır	rt	13	2012	- wa	1 12	. 190	enter									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #9, State of Mary Said & Department of Health and Mental Hygiethe For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 28 2012 12:44 P M January Ali Salahuddin Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Baltimore Gilchrist Hospice Towson 9. Birthplace (State or Foreign Country) und 1938 Washington, DC 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth **Funeral** 040-64-6196 Days Hours 1 X M 2 🗆 F Director Usual Residence of Decedent 10b. County unk 28a-f shov 10a. State 10c. City, Town or Location 10d. Inside City Limits Director unk Washingtoh the Medical Examiner must be notified 1 ☐ Yes 2 🔀 No DC ö 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 2026 4th St NE 20002 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, Specify Cuban, Mexican, Puerto Rican, etc.)

13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, Specify Cuban, Mexican, Puerto Rican, etc.)

14. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, Specify Cuban, Mexican, Puerto Rican, etc.)

15. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, Specify Cuban, Mexican, Puerto Rican, etc.)

16. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, Specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc "natural", or ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: black Completed 3 Divorced 4 Divorced Year or Dates 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) 2 should be filed within 72 h and Mental Hygiene. 7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Vendor SElf Employed unk unk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health a item 27 i Inga Morgan - cousin unit#304: Woodbridge, VA 12236 Ladymeade Court or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 N Other (Spec in state 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore St; Baltimore, MD 21201 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate interval Between Onset and Death or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical ue to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or imjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Day Year ed by the detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform 2 🗌 No 1 🗌 Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: မ 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred 1 X Natural 5 Pending Accident Investigation Suicide
Homicide 6 Could not be

State Registrar

Medical

29a. Certific

nly one)

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c License number 11000TI

Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

determined

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. amend 22, per fh. g924 2-13-12 sm State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 0.2 1:05 AM Medical 4b. City, **Examiner** Town, or Location of Death 4c. County of Death Howard OUM 7. Age (In yrs. last birth day) 8. Date of Birth (Month, Day, Yes **Funeral** If Under 24 Hrs. 8 1 🗆 M 2 Months **Director** ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10d. Inside City Limits Director 1 Yes 2 □ No 1a et and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 034 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 1 Never Married 2 Married à Yes 2 No Yes, Give Baltimore, Maryland 21215-0036 1 Tes 2 No Completed 3 Widowed 4 □ Divorced Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event the Mental. Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) မ 19a. Informant's Name/Relationship (Tv SON 20a. Method of Disposition 20b. Place of Disposition (Name of 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License 23a. Part 1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or iinjury that initiated events Date to for each consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-transit Due to (or as a consequence of): resulting in death) Last physician Completed by Physician/Medical Records, P.O. Box 68760 been signed by the attending should be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown 4 Pregnant a Month Day Year Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy perform death? certificate 1 🗌 Yes Yes Division of Vital director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner's 1 Yes Other: Certificate: To ER/Outpatient 3 DOA 1 Inpatient 2 I 4 Nursing Home 5 Residence 6 Other (Spec within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical Lactifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29c. License number 7012 person who completed cause of death (Item 23a) (Type, Print) Name and address 33 31. Date filed (Month Day) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 9 2012 Harivadan S. Shah February 12:50 A M 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Silver Spring Montgomery Holy Cross Hospital Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 7. Age (In yrs, last birthday) Hours 212-92-1046 1 🛛 M 2 🗆 F November 21, 1940 India 71 Usual Residence of Deced 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 X No Silver Spring Maryland Montgomery 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 11200 Lockwood Drive, #1416 20904 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Black, White, etc. 1 Never Married 2 X Married ☐ Yes 2 X No If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: Asian Indian 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 4 Accountant Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Sakarlal Shah Taraben Shah 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20904 11200 Lockwood Drive, #1416, Silver Spring, Maryland Bhanumati Shah/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place) February 4 ☐ Donation 5 ☐ Other (Specify) West Arundel Crematory <u> 2012</u> Odenton, Maryland 21. Signature of Funeral Service Lice .22. Name and Address of Facility Donaldson Funeral Home & Crematory, P.A. 1411 Annapolis Road, Odenton, Maryland 21113 Will Erous **7**M00672 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death a Myocardial Infarction Two Hours Due to (or as a consequence of One Month Heart Failure Due to (or as a consequence of): One Year Coronary Artery Disease Due to (or as a consequence of) 23d. Date of delivery

Department of Health and Mental Hygier Important: If item 27 is marked other and injury or other transponents. Physician/ Medical Examiner

burial-transi

attending physician I for use as the buria

signed by the at

been

has page 2

filled in by the funeral director,

after death.

Director; After this

Hospital within 24 hours a To the Funeral I

or Attending Physician: The law requires that the death certificate be

P.O. Box 68760

Division of Vital Records,

and

Physician/

Medical

10a, State

Examiner

Funeral

Director

28a-f show with the Maryland

items death

ò

"natural",

al Hygiene.

Maryland 21215-0036

Baltimore,

within 72 hours after

notified at

must be 23a

Examiner

the Medical

Director

Funeral

þ

Completed

Be

မ

Examine Physician/Medical 2 Completed Be ဂ္ Certificate:

Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Yes 2 No 1 X Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

D23805

February 9, 2012

Registrar DHMH 17 Rev 06-2011

State

Daniel Woronow, M.D., 1400 Forest Glen Road, Suite 215, Silver Spring, MD 20910

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

31. Date filed (Month, Day, Year,

FEB 1 3 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
AMEND ITEM#30 per DVR, G924, 2/13/2012, WS
State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death FEBRUARY 7, 2012 Physician/ 5:55 PM MORTON SHAPIRO Α Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE NORTHWEST HOSPITAL CENTER RANDALLSTOWN If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 **X** M 2 □ F Months Hours Min (Month, Day, Year) 08/16/1922 Director 214-14-5284 89 MD Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at with the Maryland Director 1 Yes 2 X No BALTIMORE MD OWINGS MILLS 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4501 SPRINGWATER COURT, #D 21117 USA Page 1 and 2 should be filed within 72 hours after death v ment of Health and Mental Hygiene. 12. Was Decedent Ever in U.S. Armed Forces?

1 ★ Yes 2 □ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. o. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify 3 Widowed 4 Divorced WHITE Year or Dates injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) STORE MANAGER CLOTHING Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ SHAPIRO GOODMAN MILTON BERTHA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau JUNE SHAPIRO/WIFE SPRINGWATER COURT, #D, OWINGS MILLS, MD 21117 4501 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 02/09/2012 4 ☐ Donation 5 ☐ Other (Specify) BETH TFILOH CONGR. BALTIMORE, MD Signature of Funeral Service Live ise SOL LEVINSON & BROS., INC. 22. Name and Address of Facility 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Acute Myocardial Infarction Immediate Cause (Final possible Physician disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner pulmonary embolism possible Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Certificate: To Be Completed by Physician/Medical P.O. Box 68760 IF FFMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death 1 Yes 2 9 Unknown 2 No a Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? syncope 1 Yes 2 No 3 Probably 4 Onknown Records, 24b. Were autopsy findings available prior to completion of ause of death? 24a. Was an autonsy perform 1 Yes 2 No 1 Yes 2 110 Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospita 1 ☐ Yes 2 ☑ No Other: 1 Ninpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide M Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and illuminar as stated.
2 Medical Examiner; On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier only one) 29b. Signature and title of certifie 29c, License number 29d. Date signed (Month, Day, Year) D0070086 02/08/2012 Mattasser masely 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 Thattassur Northwest Hospital Center Baltimore, Md 31. Date filed (Month, Day, Year) State FEB 1 3 2012 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month February 3, 20°1°2 6:15 P. M James Edwin Thompson, Jr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Carroll Westminster Golden Living Center If Under 1 Year I If Under 24 Hrs. g. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Ye Feb. 10, 1 1 ₺ M 2 □ F Washington D.C. 84 1927 Director 578-22-8232 Usual Residence of Decedent 23a or 28a-f show 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 No Finksburg Carrol1 MD 10g. Citizen of What Country? 10e. Street and Numbe 10f. Zip Code Funeral 21048 2213 Green Mill Road "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. White, etc. ģ 1 Never Married 2 X Married 1 X Yes 2 ☐ No If Yes, Give and 2 should be filed within 72 hours after of Health and Mental Hygiene. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: Specify 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Construction Construction Foreman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Elizabeth Poole James Edwin Thompson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2213 Green Mill Road; Finksburg, MD 21048 permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Richard Thompson 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 K Cremation 3 Removal from State Glen Burnie, MD 2/11/2012 Atlantic Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facilit Sterling Ashton Schwab Witzke 21. Signature of Funeral Ser Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville MD 21228 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Enter the disea shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition DEME Physician/ Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions if any, leading to immediate cause. Enter Underlying Examine ISEASE that the death certificate be executed Cause (Disease or linjury that initiated events and trar resulting in death) Last burialattending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Live Birth 2 Fetal death
Pregnant at time of death Ectopic pregnancy in the past 12 months Year Month Day 2 1 M 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available 24a, Was an prior to completion of cause of death? Jas autopsy performed? 2 4 1 Tyes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 2 1400 ပ 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: 5 \square Pending Natural 1 🗌 Yes 2 🗌 No s after death Accident Investigation completed filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) hours Funeral Medical 🖫 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 24 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one

State Registrar

DHMH 17 Rev 7/2009

McCalm due,

and address of person who completed cause of death (Item 23a) (Type, Print)

K

aman

31. Date filed (Month, Day, Year) FEB 1 3 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. nd #19a Per INF G924 2/21/2012 JH State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ February 2012 10:20 PM Francis Xavier Thanner Jr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Essex Baltimore Riverview Nursing Home 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Age (In yrs. last birthday) Hours Oct 1, 1946 Days Min. Maryland **Director** 213-46-4403 1 🛛 M 2 🗆 F 65 Usual Residence of Decedent 28a-f show ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1√2 Yes 2 □ No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21212 USA 622 Harwood Ave. 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc þ 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 X No Specify: Specify: "natural", Completed 3 Widowed 4 Divorced Year or Dates or other traumatic event, the Medical 16a. Decedent's Usual Occupation unk (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry unk (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 12 0 is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental ျ Francis Xavier Thanner Sr. Mary Theresa Geary 19a. Informant's Name/Relationship (Type, Print)
Lesley Ellen Nomberger wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health al Important: If item 27 is 622 Harwood Ave; Baltimore, MD 21212 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Funeral Ser 22. Name and Address of Facility State Anatomy Board any 655 W. Baltimore St; Baltimore, MD 21201 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ for in the past 12 months? Month Day Year Pregnant at time of death ned by the af detached f 2 No g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2: has autopsy certificate 1 🗌 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 No မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28b. Time of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural injury work?
1 Yes 2 No 5 Pending Accident Investigation within 24 hours after death

To the Funeral Director: A

completely filled in by the Accider Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) 02 - 05 - 2012 29b. Signature and title of certifier D-38754 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EASTERN BLUD, MD-21221 NASERM. 7091 Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 3 Month **Physician** FRANK 130 2012 EBRUDR /Medical 4c. County of Death 4a. Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death Examiner Johns Hopkins Bayview Medical Center **Baltimore** 8. Date of Birth (Month, Day, Year) Feb. 7,1926 Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 7. Age (In vrs. last birthday) 5. Social Security Number 6. Sex 1 X M 2 □ F **Funeral** Maryland 214-20-6118 85 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10d. Inside City Limits 10c. City. Town or Location 10a, State 10b. County ms 23a or 28a-f show must be notified at 1 ☐ Yes 2 No Dundalk Director Baltimore MD 10g. Citizen of What Country? 10f. Zip-Code 10e Street and Numbe 7307 Alvah Avenue United States 21222 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) items 2 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 11. Marital Status ural", or iten 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2X No Specify Specify: þ White 3 ™ Widowed 4 □ Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry 15. Decedent's Education event, the Medical (Specify only highest grade completed) Elementary/Secondary (0-12) 12 Years College (1-4 or 5+) Steel Industry Clerk other 1 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Tiburzi Bernadine Mariano Trotta marked 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health an
Important: If item 27 Is
any Injury or other trau 60 Dundalk, Maryland 7307 Alvah Ave. Dennis M. Trotta (Son) Baltimore. 20c. Location - City or Town, State 28b. Place of Disposition (Name of cemetery, cramatory or other place) Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from Staff of Jesus Cem2/7/2012 Dundalk, Maryland 6d/Ht. ☐ Other (Specify) 4 Donatt 21. Signature of eral Servi, e Licens 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 Approximate Interval Between Onset and Death Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final H.A.S. YEARS ▶ Physiclan disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) physician and s the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical as t attending IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 - Ectopic pregnancy Year Month Day ģ in the past 12 months? Pregnant at time of death 5 Other (specify) 2 No Yes detached the 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ page 2 should be 2 No 3 Probably 4 Minknown 1 TYes Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has 2 No 2 🗌 No 1 Tes 1 TYes or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 \(\) Nursing Home \(5 \) Residence \(6 \) Other (Specify) Hospital: 1 ☐ Yes 2 No 2 R/Outpatient 3 DOA 1 Inpatient ၉ After this filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 5 Pending investigation Injury 1 Natural 1 🗌 Yes 2 🗌 No death. 2 Accident Director; 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 4 Thomicide after To the Hospital within 24 hours a To the Funeral C the Hospital 1 Mertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

11+1

IL

29b. Signature and title of cartifier

MO 32 Registrar's Signatu parke

and manner stated

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

4940 Eastern Avenue, Baltimore, MD, 21224

29d. Date signed (Month, Day, Year)

State Registrar

completely

Medical

one)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death Physician/ 3:00 AM JOSEPH TENDLER 02 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death GOOD SAMARITAN HOSPITAL BALTIMORE N/A Social Security Number 7. Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Birthplace (State or Foreign Country) 1 🗷 M 2 🗆 F Months Hours Min 1271571932 Director 069-34-1848 79 Usual Residence of Decedent 28a-f shov with the Maryland must be notified at 10c. City. Town or Location Director 10d. Inside City Limits 1 🗆 Yes 2 🖁 No MD BALTIMORE BALTIMORE 23a or 2 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 403 YESHIVA LANE, APT. 1C USA permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu once. 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🔼 No If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc 1 Never Married 2 X Married and 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify. 3 Widowed 4 Divorced WHITE 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) RABBI / PRINCIPAL EDUCATION Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည ISAAC TENDLER BELLA BAUMRIND Mary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ESTHER TENDLER/WIFE 403 YESHIVA LANE, APT. 1C, BALTIMORE, MD Baltimore, | 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 Donation 5 Other (Specify) AGUDATH ISRAEL CEM. 02/09/2012 BALTIMORE, MD 21. Signature of Function and age Lin SOL LEVINSON & BROS., INC. 22. Name and Address of Facility 8900 REISTERSTOWN ROAD, PIKESVILLE, 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury CORDNARY use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No for Pregnant at time of death 5 Other (specify) Month Dav Year 1 Yes 2 9 Unknown the detached g Unknown ò Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be Dulmohary 1 Yes 2 No 3 Probably 4 1 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an certificate has autopsy performed? Yes 2 No 2 💢 No 1 Yes director 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 X No Other: 1 Yes မ To the Hospital or Attending Physical by within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral directors. 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) 27. Manner of Death بغ 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural work?
1 \(\sum \) Yes 2 \(\sum \) No injury 5 Pending Certifica Investigation Accident Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29b. Signature and title of certified 29c, License number 5601 Lock Raven Blvg 30. Name and address of person who completed cause of death (Itam 23a) (Type, Print)

(SANTOSH J. HI TAL, MD. GOOD Saman Lan Apspital) 1 DATTAL, MD. 32. Registrar's S

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ **GEORGE** Ε. WOODS 9,2012 7:50P M FEBRUARY Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 1214 RUSTIC AVENUE ROSEDALE BALTIMORE Social Security Numbe If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Days 214-12-3334 **Director** 1 XM 2 - F 94 Yrs 3-20-1917 MARYLAND 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f sho Examiner must be notified at Director MD BALTIMORE ROSEDALE 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1214 RUSTIC AVENUE 21237 U.S.A. death v 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ XNo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. by 1 Never Married 2 Married 1 Yes If Yes, Give Maryland 21215-0036 72 hours after 1 Yes 2 X No Specify. "natural", Completed 3 X Widowed 4 Divorced WHITE Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) d Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4 or 5+) 12 RAILROAD B & O Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) **JESSE** WOODS MARY С. POWELL should and Me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health a Important: If item 27 is any injury or other trau GARY P. WOODS/SON 1214 RUSTIC AVENUE ROSEDALE, MD 21237 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2X Cremation 3 Removal from State 4 Donation 5 Other (Specify) METRO CREMATORY 2-13-2012 CATONSVILLE, MD Signature of Funeral Service Licenses 22. Name and Address of Facility CVACH / ROSEDALE FUNERAL HOME 1211 CHESACO AVENUE ROSEDALE, 21237 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Retween Immediate Cause (Final Onset and Death Physician MYOC al disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence or). Due to (or as a consequence of) resulting in death) Last Physician/Medical that the death certificate be Box 68760 the attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Year Day Pregnant at time of death the 9 Unknown 9 Unknown P.O. by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, Hospital or Attending Physician; The law requires 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? Yes 2 No this certificate has 1 Yes 2 No 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner' Hospital Other 2 No 1 🗌 Yes ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home SXXResidence 6 Other (Specify 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No thin 24 hours after death.

the Funeral Director; After place of the function Accident М Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and tiple of certifier 29c License number 000697

Registrar DHMH 17 Rev 06-2011

State

30. Name and ad

31. Date filed (Month, Day, Year)

Bal

of person who completed cause of death (Item 23a) (Type, Print) 7602

Bel

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
mend #8 Per FH G924 2/16/2012 JH
State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ February 2012 Wade Hamp Williams, Jr. 9:55 AM M Medical Examiner 4c. County of Death Howard 4a. Facility Name (if not institution, give street and number) 4b. City Town, or Location of Death Columbia Gilchrist Hospice Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month) day, Year) 6. Sex If Under 1 Year If Under 24 Hrs. **Funeral** Days Hours 216-62-1329 1**X**□M 2□F Director May 5, 1953 Maryland 58 9 5 Usual Residence of Decedent an "natural", or items 23a or 28a-f show Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🗶 No Ellicott City Maryland Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21043 4827 Worthington Way Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces Black, White, etc. þ 1 Never Married 2 Married Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) the 12 Heating Master Contractor Heat & Air Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Bessie Ardella Goode Wade Hamp Williams, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 4827 Worthington Way, Ellicott City, Maryland 21043 JoEllen Williams - Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State permit. Page 1
Department of
Important: If it
any injury or o Meadowridge Mem. Park 02/13/2012 Elkridge, Maryland Donation 5 Other (Specify) 22. Name and Address of Facility Gary L. Kaufman F.H. @ MMP 21. Signature of F uneral Service Licepae 7250 Washington Blvd., Elkridge, Maryland 21075 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Lest only one cause on each line. Interval Between Onset and Death
JUNE 2011 Immediate Cause (Final GLIUBLASTOMA MULTIFORME Physician/ disease or condition resulting in death) wedical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) burial-transi Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical 68760 as the l IF FEMALE: nse 23d. Date of delivery 23b. Was decedent pregnant Box in the past 12 months?

1 Yes 2 No
9 Unknown Dav ate has been signed by the a page 2 should be detached f P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Records, 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? performe 1 Yes Yes 2 No completely filled in by the funeral director, 25. Was case referred to medical examiner?
1 Yes 2 No Division of Vital Be 26. Place of Death (Check only one) Other: HOSPICE မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 YOther (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? e Hospital or Attending Pl 124 hours after death. e Funeral Director: After the Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending 1 Yes 2 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 only one) 29b. Signature and title of certifie 064395 FEBRUARY 9, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6336 CESAR LANE COUMBIA, MS 210-44 DOBERMAN, MD DANIEUE 32. Register's Sign

Registrar DHMH 17 Rev 06-2011

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND ITEM#1perPHYS#17.19a.perFH.G924.2/13/2012, WS State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Robert Winegrad Physician/ Month 20:25 PM 2012 Medical bruan 4a. Facility Name (if not institution, give street and number, wn, or Location of Death **Examiner** 4b. City, Td 4c. County of Death 101 More Social Security Number 7. Age (In vrs. last birthday If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Director 219-28-1433 1 X M 2 □ F 80 04/20/1931 MD shov at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Maryland Director must be notified 28a-f 1 X Yes 2 No MD N/A BALTIMORE P 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 100 HARBORVIEW DRIVE, #1601 21230 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No If Yes, Give 14. Race - American Indian item 27 is marked other than "natural", or iter other traumatic event, the Medical Examiner Black White etc. ģ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after 1 Yes 2 No Specify: Completed 3 Widowed 4 Divorced Year or Dates WHITE 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) ATTORNEY LEGAL Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Winegrad WINEGARD ပ IRVING DOLORES 19a. Informant's Name/Belationship (*Type, Print*)
Winegrad
WINEGARD / W 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health attem 27 i WIFE 100 HARBORVIEW DRIVE, #1601, BALTIMORE, MD 21230 item 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of Important: If it any injury or o cemetery crematory or other place)
ANSHE EMUNAH
AITZ CHAIM 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 02/10/2012 BALTIMORE, MD Funeral Service License 22. Name and Address of Facility 21. Signature SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Ph. sician/ ACUTE MYELOJD LEUKEMIA disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) physician s the burial Physician/Medical Box 68760 38 attending | for use as IF FEMALE nse 23c. If yes, outcome of pregnancy 1 Live Birth 2 Li Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Dav Year Pregnant at time of death signed by the at Id be detached for 2 No g Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an Jas page 2 perform certificate I 2 🗌 No Yes 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 2 No 1 Tes ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this To the Funeral Director: After thi completely filled in by the funeral 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred the Hospital or Attending hin 24 hours after death. (Month, Day, Year) Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide М Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) within 7 29b, Signature and tole of certifier 29c. License number MD 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Q LAROCHELLE MARC MN (000 Move 31. Date filed (Month, Day, Year, 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Alfred Andreas Zeller February 2012 9:26 Ам Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4c. County of Death N/A 4b, City, Town, or Location of Death Good Samaritan Hospital Baltimore 5. Social Security Numbe 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Germany **Funeral** 8. Date of Birth Months 1 X M 2 D F Hours 218-32-0767 87 Director Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10b. County be filed within 72 hours after death with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits Baltimore N/A Maryland 1 X Yes 2 No 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral 21214 3408 Mary Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force à Black, White, etc. 1 Never Married 2 Married Yes 2 No Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 X No Specify: White "natural", Specify: Completed Year or Dates permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important; If item 27 is marked other than "natur any Injury or other traumatic event, the Medical! 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Machinist Industry Supervisor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Karoline Raab မ Andreas Zeller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8620 Oak Road Parkville, Maryland 21234 Mrs. Geraldine Davis - Companion Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Parkwood Cemetery 1 🛛 Burial 2 🗆 Cremation 3 🗆 Removal from State 02-17-2012 Baltimore, Maryland 4 Donation) 5 Other (Specify) 21. Signature of F 22. Name and Address of Facility 5305 Harford Road Leonard J. Ruck, Inc. Baltimore, Maryland 21214 23a. Part 1. Enter ne c sease, or complicatio s that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or he in fajure. List only one cay is on each line. Immediate Cause (Fir al Onset and Death -Physician/ disease or condition resulting in death) Medical Due to (or as a col Examiner ¿www) Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury To the Hospital or Attending Physician: The law requires that the death certificate be executed ig physician and as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 attending properties for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Pregnant at time of death Month Day Year 1 Yes 2 9 Unknown cate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed certificate I 1 Yes 2 1No director, e B 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 1 No Hospital: Other: မ 1 Inpatient 2 ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) this nours after death.

neral Director: After this if filled in by the funeral di 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation
6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a To the Funeral C Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29d. Date signed (Month, Day, Year) npleted cause of death (Item 23a) (Type, Print)

Registrar

State

Amend 4b per funeral home 2/22012 WCHD JW 12-00904 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Ronald Lee Bohn State of Maryland / Department of Health and Mental Hygiene 2012 03984 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Physician/ Month Day Year Madical Examiner 1827 hrs January 30, 2012 Ronald Lee BOHN 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death -Smithsburg Hagerstown 22161 Pondsville Road Washington If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In vrs. last birthday) if Under 1 Year **Funeral** Months Days Min. Hours Director Country Maryland 1X M 2 F 212-38-9545 70 June 25 1941 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 Yes 2 No 28a-f show Maryland Washington Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiest and an attain all, or items 23a or 28a-f she ansit. If tiens 27 is marked other than "natural", or items 23a or 28a-f she or other traumatic event, the Medical Examiner must be notified at once or other traumatic event, the Medical Examiner must be notified at once Director Hagerstown 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 22161 Pondsville Road 21742 Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 X Married 1 X Yes 2 4 Divorced If Yes, Give Year or Dates: 1 Yes 2 X No specify: Specify: White 2 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed Elementary/Secondary (0-12) College (1-4 or 5+) MD 21215-0036 Sales Wholesale Food 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname) Charles S. Bohn <u>Virginia L. Barber</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Penelope Bohn - Wife 22161 Pondsville Road, Hagerstown, Md. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State ltimore, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State partment o 4 Donation 5 Other Specify. Rest Haven Cemetery /4/2012 Hagerstown, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Minnich Funeral Home Value 415 E. Wilson Blvd. Hagerstown, Maryland 21740 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and **Physician** failure. List only one cause on each line. **!Medical** Death a. Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as e consequence of): Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed and Physician/Medical UNPENDED AMENDED signed by the attending physician be detached for use as the burial Box 68760, IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy 23d. Date of delivery Live birth Fetal death 3 Ectopic pregnancy Month Day Year 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. <u>۾</u> 1 Yes 2 No 3 Probably 4 V Unknown **Diabetes Mellitus** Completed 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of this certificate has performed? death? 1 ✓ Yes 2 No 1 🗸 Yes he Hospital or Attending Physician: Tin 24 hours after death.
he Funeral Director: After this certifica pletely filled in by the funeral director, pa 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other: Scene 1 🗸 Yes 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 V Natural 1 Yes 2 No 5 Pending 2 Investigation Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 6 Could not be Suicide or Town, State) determined Homicide 29a. Certifier 1 To the Hosp within 24 ho To the Func completely f Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Sa Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) MD O.C.M.E. January 31, 2012 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 Laron Locke MD. 31. Date filed (Month, Day Year) 32. Régistrar's Signature lottered. Registrar

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last, 2. Date of Death 3. Time of Death Physician/ Month 1:33 20/3 Melissa Copenhaver Birkland Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Meritus Medical Center Hagerstown Washington Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign Days **Director** 1 🗆 M 2 💢 F 216-48-6358 57 Dec. 9, 1954 Maryland iral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1019 Matthew Court 21742 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. "natural", or þ 1 Never Married 2 Married ☐ Yes Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced Year or Dates White permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Vocational Helper 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Vernon Birkland Laura Nell Crawley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carmen Bundick / Agency 433 Brewer Ave., Hagerstown, MD 21742 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place. Ridge Cemetery | 2/3/2012 Thurmont, Maryland 21. Signature 22. Name and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania Ave., Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Retween Immediate Cause (Final Onset and Death Physician/ Myorandra disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Exami Cause (Disease or injury that initiated events resulting in death) Last that the death certificate be executed inomin. Due to (or as a consequence of): burialattending physician I for use as the buris Physician/Medical 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery Box 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? the i g Unknown signed by the P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 1 Yes 2 No 3 Probably 4 Unknown should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy certificate 1 Yes 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 Yes Other 2 100 ပ ER/Outpatient 3 DOA 1 Inpatient 4 Nursing Home 5 Residence 6 Other (Specify) funeral Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred After To the Hospital or Attending Natural 5 Pending iniury work? 1 ☐ Yes 2 ☐ No Division 2 Accident
3 Suicide Investigation 6 Could not be filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 5060396 30 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1126 FARID H ED MUP town 31. Date filed (Mo Registrar's Signatur Registrar

DHMH 17 Rev 06-2011

of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ January 30 2012 10:53 P M Ethe1 Barber Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 135 West Main Street Sharpsburg Washington Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year, Birthplace (State or Foreign Country) **Funeral** If Under 1 Year If Under 24 Hrs. Director 201-26-7845 1 M 2 W 75 10/9/1936 Massachusetts ms 23a or 28a-f show must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Sharpsburg 10f. Zip Code Yes 2 No MD Washington 10e. Street and Number 10g. Citizen of What Country? items 23a Funeral 135 West Main Street 21782 S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Examiner Black, White, etc. or 1 Never Married 2 Married þ 72 hours after Maryland 21215-0036 1 Yes 2 No Specify. "natural", 3 ₩Widowed 4 □ Divorced Completed Year or Dates White other traumatic event, the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) other than Elementary/Secondary (0-12) College (1-4 or 5+) should be filed within and Mental Hygiene. <u>Homemaker</u> Domestic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Francis William McArdle Christine Bamford 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s f Health item 27 Melissa Higdon / Daughter 206 South Hall St., Sharpsburg, MD 21782 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 0 1 Burial 2 Fremation 3 Removal from State injury o Smithsburg Crematory2/2/2012 4 Donation 5 Other (Specify) Smithsburg, Maryland 21. Signatura 22. Name and Address of Facility Rest Haven Funeral Chapel any 1601 Pennsylvania Ave., Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Ph si⊓ian disease or condition Ovarion Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease of Injury that initiated events Due to (or as a consequence of) burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 as attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Day Year signed by the at Id be detached fo Pregnant at time of death 9 Unknown Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 certificate has performed 1 Yes 2 No Yes 2 No 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 ☑ No Hospital Other: မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, 27. Mann of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 5 Pending Natural 2 Accident
3 Suicide
4 Homicide 24 hours after death Funeral Director: A 1 Yes 2 No Investigation completely filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Muchael 41667 lowned 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MªCo1

DHMH 17 Rev 06-2011

State Registrar

Michae

31. Date filed (Month, Day

Comos

11110

mack

Please Type or Print in Black Indelible Ink. Ensure Ail Copies Are Legible.

12 000 .0	ricase Type of Fillician Diagrams made man Endage
Harry Harrison Cook, Jr.	State of Maryland / Department of Health and N

Mental Hygiene

		1- For State Certificate of Death Reg. No.													
Physici		T 1. Decedent's Name (First, Middle,Last) 2. Date of Death 3										3. Time of Death			
¹ ~lical Exami		Month Day Year 1832 hrs										1832 hrs			
Tour English	HARRY HARRISON COOK, JR 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death														
		102 Wye Knot Court	n, give street and II			٦	Queens						Queen A		
		•							46.1.1	04::	0.5:	Di			mlana /04-4: -
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. la	ast birtho	day)	If Under 1		If Under					9. Birth Foreign	nplace (State or
Director	rector 214-72-0656 1XM 2 F 53 Yrs. Months Days Hours Min. MAY 1, 195									1958		Countr MARYLAND			
	ŀ														
any	ŀ	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside										10d. Inside City Limits			
											1 Yes 2 X No				
and report	5	MD QUEEN ANNE'S QUEENSTOWN													
Aaryland 28a-f show 1 at once.	끃	10e. Street and Number 10f. Zip Code 10g. Citizen of What								at Coun	try?				
0036 within 72 hours after death with the Maryland jone. ber than "natural", or items 23a or 28a-f abo Medical Krancher must be posified at once.	Director	102 WYE KNOT COURT 21658 UNITED S									STAT	res			
1 23 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	ᅙ	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-									an Indian, Black,				
fe if w	힅	1 Never Married 2 X M		orces?		If Yes	s, specify C	uban, M	Mexican,	Puerto R	ican, etc.)		White	, etc.	
or i	Fune		1 Yes	2 X No		، 🗆 ۷	Yes 2X	Na					Specify:	WH	ITE
afte incr	á		orced If Yes, Give Ye or Dates:									140	100		
ours		15. Decedent's Education (Spe					s Usual Oc st of workin					101	b. Kind of Bus	siness/ir	idustry
72 h	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)							/				
F th Bi 30	ᅙ	12			BAI	LANC	ING T	ECH	NICIA	AN			SHEET	г ме	TAL
5-0036 led within 72 Hygiene. other than	Š	17. Father's Name (First, Middle	, Last)					18	.Mother's	Name (First, Middle	e, Maid	en Surname)		-
	Be	HARRY HARRI	SON COOK	SR					MA	DA (TATHER	TNE	E WIECH	IMAN	
112 Id be fenti	9	19a. Informant's Name/Relations		OK .	19b	Mailing	Address (Street					, City or Town		Zip Code)
D 21 should and Mer 7 is man	F				7/1	-	,						-		
imore, MD 2121 Pages 1 and 2 should be fi men of Health and Mental lant: If item 27 is marked or other traumatic event,		GAIL ANN COOK	/ WIFE	Logi			YE KN				JEENS. Date		oc. Location -	216	
Tite Hear		20a. Method of Disposition 1 Burial 2 X Cremation	a 2 Demoval	rom State	Piace of cremator	Dispositi ry or othe	ion (Name er place)	or ceme	stery,		Date	20	oc. Location -	City or	iown, State
ages nt of tt. II				CH:	ESAP	EAKE	er place) CREM R	IATI	ON	01/2	8/201	2	TVTTZ	NCV	LLLE, MD
Baltimore, permit. Pages 1 as Department of He Important: If ite injury or other tr		4 Donation 5 Other S 21. Signature of Funeral Service				LIVIE 22 Na	Me and Ad	dress o	f Facility	01/2	0/201	2			
Sal ermi epar mpo		21. Signature of Fulleral Service	LICE ISO	1 -		FEL	LOWS,	HE	LFEN	BEIN	& NE	WNA	M FUNE	RAL	HOME, P.A.
	G 7.5	> 1	10			1408	S. L	1 TBE	RTY	ST.	CENT	REV	LLLE.	MD 2	2161/
Physician		23a. Part I. Enter the disease, or failure. List only one cause		caused the death	. Do not	enter the	e mode of d	ying, si	uch as ca	irdiac or r	espiratory	arrest,	snock, or nea	ırt	Approximate Interval Between Onset and
Medical	7.79	Immediate Cause (Final disease	Cantant	hotgun Wour	nd of th	ne Tors	80								Death
Examiner		or condition resulting in death)		a consequence of											,
			b.												
	b	Sequentially list conditions, if any, leading to immediate	Due to (or as	a consequence of	of):										
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated	0.												
	ᡖ	events resulting in death) Last	Due to (or as	a consequence o	of):										
ecuted and transit			d.												
execution and and and and and	8	UNPENDED	AMENDED	•											
1760, ficate be exe g physician a	/Medical											-	23d. Date of	doliven	
760, ficate be g physic		IF FEMALE: 23b. Was decedent pregnant in t		, outcome of preg birth		- Foto	al death	3	Ectopic	pregnan	rv.	- 1	Month Month		ay Year
Serti:	<u>i</u> ë	past 12 months?		nant at time of de		_	er (Specify			p. 09. io	-,	- 1		_	,
P.O. Box 687 s that the death certifi gred by the attending c detached for use as t	Physician	1 Yes 2 No 9 Ur	tracum I I	nown	3	Oth	er (Specify	<i>'</i> —				- 1			
hed of	훉	Part II. Other significant condi			eculting	in the un	derlying ca	use div	en in Par	+ 1	23e Di	d tobac	co use contril	bute to t	he cause of death?
P.O. es that the igned by	b	Part II. Other significant condi	done contributing	to death bachoth	counting	in the di	idenying oc	aso giv	on in rai					_	ably 4 Unknown
sign be o	ğ								-		' 🗀	163 2	Z W INO S		ably 4Onklown
of Vital Records, Pag Physician: The law requires the this certificate has been sign meral director, page 2 should be c	Completed										24a. W	as an			opsy findings available ompletion of cause of
law has has 2 sh	ᅙ										ре	rformed	d? d	eath?	
ician: The certificate	Ņ										1 ✓ Ye	s 2	No 1	√ Ye:	s 2 No
ial Relian: The certificate	Be	25. Was case referred to medica					26.		of Death (Check or	nly one)				
Vita hysical this c	0	examiner? 1 ✓ Yes 2 No	Hospital: 1	Inpatient 2	ER/Out	tpatient	3 DOA	10	ther4	Nursing	Home 5	Res	sidence 6 🗸	Other:	Scene
ding Phy	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred									ed					
fr. fr. fr.	[편]	1 Natural 5 Pen	ding Jan 23	th, Day Year) , 2012	1800	hrs		Ye	s 2 🗸	No S	ubject s	not se	elt		
Sior Attend r death rectors	ᄬ	2 Accident Inve	estigation	ice of Injury - At h	ome for	m atroof	factory	ffice but	ilding etc		Of Location	n (Stree	et and Numbe	r or Rur	el Route Number, City
Division to a for	🗐		ild not be				i, raciory, o	nice Du	naing, etc	- 1	or Town	n. State	9)		
15 6 P	Certification:	4 Homicide determined (Specify) Single Family Home 102 Wye Knot Court, Queenstown, MD									MD				
Hos Pun Fun		29a. Certifier 1 Certifying F	Physician: To the be	est of my knowled	dge, deat	th occurr	ed at the tir	ne, date	e and pla	ce, and d	lue to the c	ause(s)	and manner	as state	d.
To the Hos within 24 h To the Fur completely	Medical	one) 2 Medical Ex	aminer: On the basis	s of examination a	and/or in	vestigation	on, in my o	oinion,	death occ	curred at	the time, da	ate and	place, and de	ue to the	e cause(s)
\$ 1 8 1 8	¥ e	29b. Signature and title of certif		J.G.Co.			29c, L	icense	number		_	29	d. Date signe	ed (Mon	th, Day, Year)
/		1 10	1 11 .222					D.C.M	l.E.			_ [J	anuary 24	, 2012	
5.		Tunuag vich	ull (MI)				`					L			
MS		30. Name and address of person who completed cause of death (Item 23a) Pamela E. Southall, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223													
1.		Pamela E. Southall, I	MD Assistan	t Medical Exa	aminer	900	w. Balti	more	Street,	Baltim	ore, MD	2122	23		
S	tate	31. Date filed (Month, Day, Year,		egistrar's Signat	ure										
	_	I A R I +2 / L		exceeded.	40	Sec. 1									

		-	For State Registrar	State of Ma	-	eparimer Certificat				g. No.			
Æ	= / 4 -		Decedent's Name (First, Middle, Last						2. Date of Death			3. Time of Death	
	Physicia		JAMES LES	SLIE COLEMAN					Month Februar	Day	Year 2012	7:30 a. ^M	
	/Medic Examin		4a. Facility Name (If not institution, give	street and number)	COBLINE	4b. City	Town, or	Location of Death	1001001	-	ty of Death		
~	LAGIIIII		Moran Manor Nurs	ing Home			West	ernport			Alleg	any	
	Funeral		5. Social Security Number 6. Se	_	(In yrs. last birth	day) If Unde Months	r 1 Year Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year)		lace (State or Foreign try)	
	Director		235-30-0357	ØM 2□F	87 Y	rs.	Dayo	110010	Nov. 20	,1924		son, WV	
	pu ,		Usual Residence of Decedent		10c. City, Town	or Location					1	0d. Inside City Limits	
	aryla shov d at											1 □Yes 2 XI Clo	
	he M 8a-f otifie	Director	MD Alle	gany	Rawl	lings	p Code		10	g, Citizen of	What Coun	trv?	
	with t	盲	10e. Street and Number	0.11		101. 21		- 7		,g, O.L.2011 01		,	
	sath s	eral	24937 Crooks Ave	12. Was Decedent B	ver in U.S.	13 Was Dece	2155		ecify Yes or No-	14. Ra	USA ace - Americ	an Indian,	
	Item Item iner r	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Forces?				spanic Origin? (Sp n, Mexican, Puerto	Rićan, etc.)	Bla	ack, White,	etc.	
39	Irs af	by I	3 Midowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes	2 X No	Specify:		Spec		ite	
5-0036	be filed within 72 hours after death with the Maryland that Hyglene. ed other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at		15. Decedent's Edu	ucation	16a. l	Decedent's Usu	ual Occupa	ation	ina I	16b. Kind of I	Business/Ind	dustry	
215	hin 7. 8. an "n Medi	Completed	(Specify only highest grad Elementary/Secondary (0-12)	College (1-4or 5	+)	life. DO NOT i	ise retired	furing most of work)	""y				
21	ed wit	Jo.	7			Mainte	nance	Dept.				ufacturing	
D D	8 - a e	Be (17. Father's Name (First, Middle, Last)					18. Mother's Name	e (First, Middle, N	faiden Surna	ame)		
<u>yla</u>	should band Ment s marked umatic e	2	David Franklin (Mae Ross				
Maryland 2121	0 0 0 0		19a. Informant's Name/Relationship (7)		ì	•	•	and Number or Rui		City or Tow	n, State, ∠ip	(Code)	
	1 and 2 Health lem 27		Kathy J. Viney/I	Daughter		L431 We Disposition (Na		<u>lena Blv</u>		ora, I			
or o	0 0		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐		cemeter	, crematory or	other plac		/12	Loc. Location	, only of the	m, state	
Ē	tmen tant:		4 □ Donation 5 □ Other (Specify	1	Restla			Gardens		LaVal	Le, MD		
Baltimore,	permit. Pag Department Important: I any injury o		21. Signatur Houseral Servic License 22. Name and Address of Facility Smith Funeral Home 85. S. Main Street Keyser, Wy 26726										
	TD = 40 0		Control Enter the disease or some	Lications that source	the death. Do n	85	S. Ma	<u>in Stree</u>	<u>t Key</u>	ser, W	VV 26	Approximate	
65			shock, or heart failure. List only one cause on each line.										
in the	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a Ind	stage 1	lend	w	resse				yens	
	Examiner			Due to (or as	a consequence o	it):							
		Ē.	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	a consequence o	rf):							
	uted I nnsit	m.	Cause (Disease or injury that initiated events										
Ć,	exectin and ial-tra	Examiner	resulting in death) Last	Due to (or as	a consequence o	of):							
68760,	eath certificate be executed attending physician and for use as the burial-transit	edical		d									
	tifica ig ph as th	Medi											
Вох	th cer endir r use	an/N	1F FEMALE: 23b. Was decedent pregnant	/			Date of delive Month	elivery Day Year					
E	The law requires that the death cert ate has been signed by the attending agge 2 should be detached for use a	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregnant at 9□Unknown	t time of death	5 ☐ Other (specify)				Month Day You		
P.O.	at the i by the	Phy	9 Unknown		ut not requiting in	the underlying	enues siv	on in Part I	23e Did tok	nacco use co	ontribute to t	he cause of death?	
'n	res th ignec	by	Part II. Other significant conditions of		Dr sz			Alensia.				bably 4 Dinknown	
orc	w requir been si should I	ted					_11		0)				
Sec	ne law has b je 2 sl	Completed							24a. Was a autops	SV I	b. Were auto prior to co death?	opsy findings available empletion of cause of	
<u>~</u>	: The cate pag	S							perform 1∐ Yes	2∐No	1 ☐ Yes	2 □ No	
Vit	ician certifi ector	Be	25. Was case referred to medical examiner?	Hospital:			Oth	or:	th (Check only on				
or Vital Records,	Phys this ral dir	<u>۲</u>	1 ☐ Yes 2 No 27. Manner of Death	1 ☐ Inpatie	ent 2 ER/Ou	ime of	JOA	4 Nursing H	ome 5 Reside			(fy)	
no	ding n. After fune	io	1 Natural 5 ☐ Pending	(Month, Da		njury M	28c. Injur Wor 1 □	rk? Yes 2 □ No		. ,			
İSİ	Atten deatl ctor: y the	lical	3 Suicide 6 Could not be	28e. Place of inj	ury - At home, fa	rm, street, facto	ory, office				mber or Rur	al Route Number,	
Division	after after Dire	Certification:	4 ☐ Homicide determined	building, et	c. (Specify)				City or Town	n, State)			
	spita nours inera y fille		29a. Certifier	ysician: To the best	of my knowledge	, death occurre	ed at the ti	me, date and place	e, and due to the c	ause(s) and	manner as	stated.	
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page.	Medical	(Check only 2 Medical Examone)	niner: On the basis of and manner st		u/or investigati	on, in my (opinion, death occi					
	To the vithing to the complex	Ž	29b. Signature and title of certifier			2		se number	2	29d. Date sig	ned (Month)	, Day, Year)	
	1		Jam .				02	1244		2/3	3/12		
	2 Ph		30. Name and address of person who	completed cause of o	ieath (Item 23a) (Type, Print)							
			Jesus Tan, M.D.	4 Broad	lway F	rostbur	g, MI	21532					
		ate	31. Date filed (Month, Day, Year)	32. Regist	raes signature	lad							
	Regist	rar	FEB 1 3 2012	Chistra 1	7								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 7:05 George Freeman Dom kinuara Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death c. County of Death Washington Meritus Medical Center Hagerstown Social Security Number If Under 7. Age (In yrs. last birthday) 1 Year If Under 24 Hrs Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) Hours 185-14-9711 **Director** 1 🛛 M 2 🗆 F 95 Dec.5,1916 Pennsylvania Usual Residence of Decedent 28a-f show 10a. State 10b. County with the Maryland "natural", or items 23a or 28a-f sho 10c. City, Town or Location Director 10d. Inside City Limits Maryland Washington Hagerstown 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 15145 Bloyers Ave. 21740 USA permit. Page 1 and 2 should be filed within 72 hours after death . Department of Health and Mental Hygiene. 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 Now WWII
If Yes, Give
Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Completed 3 X Widowed 4 □ Divorced Specify: White er than "natura", the Medical E 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Truck Driver Retail Sales 8 is marked other aumatic event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည 127 is marked George William Dom Mary Mabel Suder 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mark S. Dom - Son 632 Highland Way Hagerstown, MD 21740 item 2 20a. Method of Disposition 20b. Place of Disposition (Name of Department of H Important: If ite any injury or ot once. 20c. Location - City or Town, State ■ Burial 2 □ Cremation 3 □ Bemoval from State cemetery, crematory or other place, 4 Dopation 5 Other (Specify) Cedar Lawn Mem. Park 02-03-2012 Hagerstown, Maryland 21. Signature of Faneral Se 22. Name and Address of Facility Osborne Funeral Home, P.A 425 S.Conococheague St. Williamsport,MD 21795 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ DIFAT W a disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** 9/2 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Cause (Disease or injury attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Pregnant at time of death ate has been signed by the a page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by att or 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 2 🗆 No 1 Yes 2 No 1 Yes completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) ည 1 Yes 2 7 1 III Impatient 2 I ER/Outpatient 3 I DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at 5 Pending 1 Aatural work Accident 1 Tes 2 No Investigation 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 [Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

12+114

egistrar's Signatur

erins

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SC

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death 9:15 a _M Physician/ 20 T2 January 25 Fawcett DeVinney, Sr. Grant Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Frederick Emmitsburg 9320 Waynesboro Pike 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign April 1 (Month, Pay 20, 1934) Washington, D.C. **Director** 77 578-42-2672 Usual Residence of Decedent or 28a-f show oe notified at 10a. State 10b County filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Frederick Emmitsburg Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or Funeral 21727 USA 9320 Waynesboro Pike 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 X Married 1 Yes If Yes, Give 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 Divorced 4 Divorced Year or Dates White permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important; If item 27 is marked other than "natur any injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Taxi Service Cab Driver Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Ruth Wagner John Clyde DeVinney Mary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9320 Waynesboro Pike Emmitsburg, Maryland Ara M. DeVinney - Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Greenlawn Mem. Park | Jan.27,2012 | Williamsport, Maryland 21. Sign Osborne Adreneral Home, P.A. 425 S. Conococheague St. Williamsport, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on _ach line. Interval Between Onset and Death Immediate Cause (Final Physician/ Medical resulting in death) to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year 2 No 9 Unknown .24 hours after death.

e Funeral Director. After this certificate has been signed by the funeral director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by PERTENSION 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 12 No Hospital: Other: 2 1 🗌 Yes 1 Inpatient 2 Impatient 3 Impa 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \square Homicide determined Medical Certi g 'hysician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Me | al | aminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Very lifting the cause(s) and manner as stated. 29a. Certifier only one 29b. Signature and title of certi 29d. Daty signed (Month, Day, Year) o person who completed cause of death (Item 23a) (Type, Print) WASH DO State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2012 January 2:20 РМ <u>Laura Margaret Eaton</u> Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Asbury Health Care Center Calvert Solomons Social Security Number 9. Birthplace (State or Foreign Country) Nebraska **Funeral** Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 1 □ M 2 👺 F Hours 0471171912 Director 99 374-16-9702 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examination 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Calvert Solomons 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20688 United States Rm#223 11750 Asbury Circle, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 A Never Married 2 Married Completed by 1 ☐ Yes 2 ऄ No If Yes, Give 1 ☐ Yes 2 L No Specify: White 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Clerical Worker U.S. Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Ralph Clenard Eaton Mary Clarice England 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara J. Miwa / Niece 110 Simerville Road, Chapel Hill, NC 27517 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Durial 2 Tremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 01/31/2012 Alexandria, Virginia 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home, P.A. P.O. Box 600, Lusby, MD 20657 23a. Part 1. Enter the diselse, or comilications that caused the drath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ FALLURE disease or condition resulting in death) 40 NTHE Medical Due to (or as a consequence of) Examiner CESTIVE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of) Cause (Disease or iinjury that initiated events resulting in death) Last and burial-tran Due to (or as a consequence of): attending physician for use as the buria P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 Mo
9 Unknown Pregnant at time of death Month Day Year signed by the at be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Unknown page 2 should . Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 25. Was case referred to medical funeral director. Certificate: To Be 26. Place of Death (Check only one) examiner? 2 19 No Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? s after death. I Director: After the 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes Investigation 6 Could not be 2 No Accident filled in by the I Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) within 24 hours a Medical Critifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed (Check 3 🗆 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 302012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DRW PRAJERICK MI KIBR

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32. Registra Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2112 For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ SHARON KAY SHIEL EGGERS JANUARY 2012 AMMedical 05:57 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death UNION HOSPITAL OF CECIL COUNTY ELKTON CECIL 9. Birthplace (State or Foreign Country) WEST VIRGINIA Social Security Number 8. Date of Birth (Month, Day, Ye **Funeral** 6 Sex Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs. Days Hours Min. 1 M 2 X F Director 217-64-4807 1954 Usual Residence of Decedent or 28a-f shov 10a. State 10b. County 10c. City, Town or Location death with the Maryland other traumatic event, the Medical Examiner must be notified at Director 1XXYes 2 □ No MARYLAND CECIL ELKTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? other than "natural", or items 23a Funeral 1 PRICE DRIVE 21921 UNITED STATES 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status . Was Decedent Ever in U.S 14. Race - American Indian Armed Forces Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked others any injury or others? þ 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 2 X No 1 ☐ Yes 2 XXNo Specify. WHITE Completed Specify: 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) HOMEMAKER OWN HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) JAMES L. SHIEL PHYLLIS F. LEE 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JOSEPH EGGERS / SON 22 BRIDGEWELL PARKWAY, ELKTON, MARYLAND 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State JANUARY 30 1 X Burial 2 Cremation 3 Removal from State NORTHER EXECUTION OF THE PLACE METHODIST CEMETERY Donation 5 D Other (Specify) 2012 NORTH EAST, MARYLAND 21. Signature of the Se 22. Name and Address of Facility CROUCH FUNERAL HOME, P.A. 127 SOUTH MAIN STREET, NORTH EAST, MARYLAND 21901 , or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a, Part 1, Enter the disease Approximate Interval Between Onset and Death shock, or heart failure Immediate Cause (Final Ph_sici_n disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 L Fetal usa Pregnant at time of death 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months? Month Day Year signed by the a d be detached f 9 Unknown Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed 1 🗌 Yes 2 🗌 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: Certificate: To 1 🗌 Yes 2 1No 1 Inpatient 2 ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred eral Director: After filled in by the funer 1 Natural 5 Pending work 1 Tyes 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check eath occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practioner: To 29b. Signature and title of certifier eted cause of death (Item 23a) (Type, Print 2192 State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Physician/ Britanu 2012 10:411 ANN FAULDER Medical Facility Name (if not institution, give street and number) or Location of Death 4c. County of Death Examiner Trauma Conter- University paltimore <u>Baltimore</u> If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Hours **Director** 219-08-7627 1 □ M 2 🏋 F 26 July 13 1985 Maryland Usual Residence of Deced Show 10c. City, Town or Location with the Maryland 10a State 10b. County 10d Inside City Limits Director notified 28a-f 1 Yes 2X No Maryland Washington Hagerstown ö 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a o Funeral 11105 Glenside Avenue 21740 death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Force Black. White, etc. þ 1 Never Married 2 K Married Yes 2 X No Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2X No Specify: White If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working nt of Health and Mental Hygiene.
If item 27 is marked other than or other traumatic event, the Me life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Convenience Store Supervisor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fili Department of Health and Mental Important. If item 27 is marked of any injury or other traumatic eve မ James Richard Peck Cynthia Marie Crawford 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Seth Faulder - Husband 11105 Glenside Avenue, Hagerstown, Md. 21740 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place, 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Cedar Lawn Mem. Park 2/7/2012 Hagerstown, Maryland Signature of Funeral Service Licenses 22. Name and Address of Facility Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Maryland 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Phonesing CERTIFICATION APPROVED STATE SICAL EXAMINES disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed and burial-trar that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Box 68760 the as IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Other (specify) 5 Other (specify) 30, Pregnant at time of death Januar 2012 9 Unknown 9 Unknown Division of Vital Records, P.O. ģ Part II Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ should be 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was ar page 2 has autopsy perform certificate I 2 No Yes 25. Was case referred to medical exeminer? Be 26. Place of Death (Check only one) Other: ျ Inpatient 2 Inpatient 3 Inpatient 2 Inpatient 2 Inpatient 2 Inpatient 2 Inpatient 2 Inpatient 3 Inpatient 2 Inpati 4 Nursing Home 5 Residence 6 Other (Specify) After this funeral 27. Manner of Death Date of injury 28h Time of Certificate: 28c. Injury at 28d. Describe how injury odcurred 1 Natural 2 Accident Month, **28** 5 Pending Motor 20 2 1700 1 Yes after death. filled in by the 1 Investigation 6 Could not be Suicide Rlace of Injury - At home, farm, street, factory, office 286 4 Homicide determined Hospital 24 hours Medical Descritiving Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Descripting Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely (Check only one within 2 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) 100983 31 2012 **QT** Name and address of person who completed cause of death (Item 23a) (Type, Print)

11 AUCHN MD 22. South Green: Sheet Bathmore, MD 21201 TU-5

State Registrar 31. Date filed Month

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend # Hate Por MEH I 6925 Debartment of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Richard J. Graim 2012 2:10 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5809 Dimes Rd. Montgomery Derwood 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 8. Date of Birth **Funeral** Country) Maryland 1 □ M 2🗓 F 89 Months Days Hours Min (Month, Day, Yea -10-1922 **Director** 215-14-6087 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10d. Inside City Limits must be notified at 10c. City, Town or Location Director Florida 1 X Yes 2 No Spring Hill Hernando P 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 7087 Crown Oaks LA 34606 United States Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. ō þ 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: White 27 is marked other than "natural", traumatic event, the Medical Exa 3X Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Government CIA Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) n and Mental I ည Raymond E. Graim Margaret Gellner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t of Health 5809 Dimes Road, Derwood, Maryland 20855 Bruce Graim - Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1
Department of
Important: If it
any injury or o 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1-27-2012 | Falls Church, Virginia National Crematory M01477 22. Name and Address of Facility Edward Sagel Funeral Direction 21. Signature of Euneral Service Licenses 1091 Rockville Pike, Rockville, Maryland 20852 Kurt Blake 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death Years shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition Physician. Chronic Obstructive Pulmanary Disease Medical resulting in death) Due to (or as a consequence of): **Examiner** 5 Years Cerebral Vascular Accident Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence or). Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury 5 Years Hypertension that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician hed for use as the burial Physician/Medical 5 Years Dementia Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? detached for Month Year Day 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ate has been signed page 2 should be de by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown Failure to Thrive Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe Yes 2 X No 1 Yes 2 No apleted filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 2 XNo ည 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After t To the Hospital or Attending within 24 hours after death.

To the Funeral Director, After the Funeral Director, After the Funeral Director, After the funeral Director, Af 1 🛛 Natural 5 Pendina 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3X Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1-21-2012 R096053 121 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) - 15245 Shady Grove Road, Rockville, Maryland 20850 Babette Pennay C.R.N.P.

State Registrar 31. Date filed (Month, Day, Year)

JAN 2 7

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 7PM Physician/ 019/25/2012 Judith Ann Gray Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 1351 Emmanuel Church Road Calvért Huntingtown Social Security Number 8. Date of Birth (Month, Day, Ye July 10, 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country)
Ohio If Under 1 Year | If Under 24 Hrs. **Funeral** Months Days Year) Hours 1 🗆 M 2 屎 F 70 Director 276-38-7607 1941 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits the Maryland Director ms 23a or 28a-f s must be notified Maryland Calvert Huntingtown 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States permit. Page 1 and 2 should be filed within 72 hours after death with I Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a may injury or other traumatic event, the Medical Examiner must by once. Funeral 20639 1351 Emmanuel Church Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S 14. Race - American Indian. Armed Forces?

1 Yes 2 No Black, White, etc. Completed by 1 Never Married 2 Married ☐ Yes Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: white If Yes, Give Specify: 3 Widowed 4 Divorced Year or Dates Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) U.S. Government Security Specíalist Be 18. Mother's Name (First, Middle, Maiden Surname)
Janet Smith 17. Father's Name (First, Middle, Last) 2 Robert Lomas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 1351 Emmanuel Church Road Huntingtown MD 20639 Robert Allen Gray - spouse 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 XBurial 2 Cremation 3 Removal from State Wesley Cemetery or other place) Prince Frederick Marylan Jan 31 2012 4 Donation 5 Other (Specify) 22. Name and Address of Facility Rausch Funeral Home PA Signature of Funeral Service Licenses 4405 Broomes Is. Rd. Port Republic MD 20676 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Dangio Carcino ma disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Linter Underlying Examine Due to (or as a consequence of) Cause (Disease or iinjury that initiated events resulting in death) Last and -tran Due to (or as a consequence of) burialphysician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the attending p for use as t IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant ☐ Ectopic pregna ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Dav Pregnant at time of death signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed' death? 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medica Certificate: To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 🔁 No ER/Outpatient 3 DOA 1 Inpatient 2 I 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural injury 5 \square Pending ours after death.
neral Director: Aff 1 Yes 2 🗌 No Accident Investigation 6 🗌 Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 24 hor To the Funer completed fil 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) and title 29d. Date signed (Month, Day, Year) 30. Name and address apperson who completed cause of death (Item 23a) (Type, Print) JRW)

State Registrar

MON 31. Date filed (Month, Day, Merrian

238

32. Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year 2012 Medical Ja Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Center nnapolis Medica curity Number 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under **Funeral** 40-7837 Months Hours (Month, Day, Year) Director 1 M 2 F -11items 23a or 28a-f show 10b. County at 10a, State 10c. City, Town or Location 10d. Inside City Limits Director ortant: If item 27 is marked other than "natural", or items 23a or 28a-f s injury or other traumatic event, the Medical Examiner must be notified 1 Yes 2 No 10g. Citizen of What Country? Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married þ 1 Yes 2 If Yes, Give Year or Dates. Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Completed 3 - Widowed 4 - Divorced Jack 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) should be filed within 7 nand Mental Hygiene. 7 is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Indu Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Department of Health ar Important: If item 27 is: arrs Baltimore, 20b. Place of Disposition (Name of 20c Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) 22. Name and Address of Facility Henry Funeral Henry Funeral Henry Funeral Henry Constitution Str C 21. Signature of Funeral Service Licenses 21613 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ 51258 disease or condition Medical resulting in death) Due to (or as a con aquence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Ener U. danying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): and Due to (or as a consequence of): attending physician I for use as the buria Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death the Division of Vital Records, P.O. been signed by should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed certificate 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Tes ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work?
1 ☐ Yes 28d. Describe how injury occurred 1 Natural 5 Pending 2 🗌 No Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certif 29c. License number 29d. Date signed (Month, Day, Year, D38178 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SiMarcho 21401 2003 Mediae Registrar's Sign State

Registrar

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Division of Vital Records, P.O. Box 68760 ompleted filled in by the

> State Registrar

Medical

29a. Certifier

only one)

Syed A.

29b. Signature and title of co

31. Date filed *(Month, Day, Year)*JAN 27

3 🗆

Sadia

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

14333

XCertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Laurel Bowie Road, #

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2012 028

		•	1 - State Registrar	Cen	tificate of Dea	ath		Reg. No	2012	. 00000	
	Physicia	n/	1. Decedent's Name (First, Middle, Last)				2. Date of Dea		y Year	3. Time of Death	
	Medic	al	MITCHEL L. HENDERSON				JANUARY	\neg		08:40AM	
	Examin	er	4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Loc NORTH EA			4c	CECIL	h	
_	Funeral		56 CARA COVE ROAD 5. Social Security Number 6. Sex 7. Age (In y	rs. last birthday)	If Under 1 Year If	Under 24 Hrs.	8. Date of Birt	:h		hplace (State or Foreign	
	Director		212-62-5372 1 X M 2 □ F 57	Yrs.	Months Days H	lours Min.	(Month, Day	y, Year)	954 KEN	ITUCKY	
	ld now	<u>_</u>	Usual Residence of Decedent 10a. State 10b. County 10c	. City, Town or Loc	ation					10d. Inside City Limits	
vielvie	arylar a-fsl	ecto								1 ☐ Yes 2 🛣 No	
	or 28 e noti	Öİ	MARYLAND CECIL 10e. Street and Number	NORTH	10f. Zip Code			10g. Cit	tizen of What Co	untry?	
:	with s 23a ust b	Funeral Director	56 CARA COVE ROAD		21901			UNI	TED STAT	ES	
	death item ner m		11. Marital Status 12. Was Decedent Ever in Armed Forces?		as Decedent of Hispa Yes, specify Cuban, M				14. Race - Ame		
936	filed within 72 hours after death with the Maryland tal Hygiene. At Hygiene. At Other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at.	Completed by	1 ☐ Never Married 2 ★ Married 1 ☐ Yes 2 ★ No If Yes, Give Year or Dates.	1	☐ Yes 2ሺ No S	Specify:			Specify: WHI		
Maryland 21215-0036	hours natur dical I	olete	15. Decedent's Education (Specify only highest grade completed)		ent's Usual Occupation		ing	16b. K	ind of Business	Industry	
21	hin 72 ne. than " e Me	om	Elementary/Seconday (0-12) College (1-4 or 5+)	life. DC	NOT use retired)		ng				
2	Hygie Hygie Sther ent, th	Be C	12 1 17. Father's Name (First, Middle, Last)	F	ACTLITATOR	. Mother's Nam	e /First Middle	4.0	CHINE Surnama)		
au	ould be filed wil	인	THOMAS MORRIS HENDERSON			MABLE R			oarramo,		
ary	hould and M is mai		19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	g Address (Street and				Town, State, Zip	Code)	
Σ	of Health and Dents of Health and Ments fitem 27 is marked r other traumatic e		PATRICIA L. HENDERSON / SPOUS	E 56 C	ARA COVE R	ROAD, NO	RTH EAS	T, l	MARYLAND	21901	
Baltimore,	Page 1 ar ment of H ant: If iter ury or oth		20a. Method of Disposition 20 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State	Db. Place of Dispos cemetery, crem	sition (Name of atory or other place)		ARY 6,	20c. L	ocation - City or	Town, State	
Ħ	permit. Page Department Important: I any injury o		4 Donation 5 Other (Spacify)		CREMATORY		1		WARK, DE		
Ba	Depa Impo any i		21. Signature Astronomical Service Reposee		Name and Address of SOUTH MA				-	P.A. CYLAND 21901	
			25a. Part 1. Enter the disease, or complications that caused the c shock, or heart failure. List only one cause on each line.					rest,		Approximate Interval Between	
- P	hysicizm/		Immediate Cause (Final disease or condition	CINOMA	RESO P	174 bu	S			Onset and Death	
1	Medical Examiner		resulting in death) Due to (or as a con	sequence of):							
		ner	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):								
	outed nd ransit	Examiner	cause. Enter Underlying Cause (Disease or linjury that initiated events c.								
	e exec cian a vurial-t	al E	resulting in death) Last Due to (or as a con	sequence of):							
8760	cate b physi s the b	Medical	d								
89	certifi inding use as		IF FEMALE: 23c. If yes, outcome of pre		Catania pragnancy				23d. Date of del	ivery	
Вох	death ne atte ed for	Physician/	1 Yes 2 No 4 Pregnant at time		Ectopic pregnancy Other (specify)				Month	Day Year	
O. :	at the	Phy	9 Unknown Part II. Other significant conditions contributing to death but no	t resulting in the u	nderlying cause given i	in Part I.	23e Did to	bbacco use contribute to the cause of death?			
ς, σ.	res th signe d be d	d by		3	, , ,					robably 4 💢 Unknown	
ord	requipers	lete					24a. Was		24b. Were au	topsy findings available	
Sec.	he fav te has age 2	Completed					autop perfo	osy ormed? 2 X N	death?	completion of cause of	
<u>a</u> .	ian: I artifica ctor, p	Be C	25. Was case referred to medical examiner?		26. Place	of Death (Chec		Z	01 103	2 110	
₹ ;	hysic his ce Il dire	10	1 Yes 2 No Hospital:	2 ER/Outpatien	t 3 DOA Other:	4 Nursing Ho	me 5 Resid	dence_6	Other (Spec	ify)	
ָם ה ה	ding P h. After t funera	Certificate:	27. Manner of Death 1 ★ Natural 5 ☐ Pending 28a. Date of injury (Month, Day, Yea	28b. Time of injury	28c. Injury at work?		28d. Describe h	ow injur	y occurred		
Sion	Attender r deatl	rtific	2 Accident Investigation M 1 Yes 2 No Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number 1)							ral Route Number,	
Division of Vital Records,	al Dire		4 Homicide determined building, etc. (Sp.	ecify)			City or Tow	n, State)		
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier 1 Certifying Physician: To the best of my k (Check 2 Medical Examiner: On the basis of examin								
	the ithin 2 the omple	ž	only one) 3 Certifying Nurse Practioner: To the best of 29b. Signature and title of certifier	of my knowledge, d	eath occurred at the time		e, and due to th		s) and manner as te signed (Month		
	+ 3 + ŏ		P.V. Naye D. MD			5733			30/2012		
	10		30. Name and address of person who completed cause of death	(Item 23a) (Type, P	rint)	00: 1	r1				
	10		NANAYANA RAN V-PULA, IV. 31. Date filed (Mark) 1994, Year 1995	ionature		> Trust	1 124	(10/	, HD 4	721	
	Sta Registr		31. Date filed Mark 13, Year 12012 32. Registrar's Si	A Sour	4						

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No 1 Decedent's Name (First Middle Last 2 Date of Death 3. Time of Death Physician/ James Stevenson Hunter 2012 10:55 P.M January Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number, 4c. County of Death **Examiner** Frederick Frederick Memorial Hospital Frederick 5. Social Security Number 6. Sex 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Hours Min Days Director 577-64-1114 1 X M 2 - F May 11, 1948 Washington, D.C. Usual Residence of Deceden 28a-f shov 10d. Inside City Limits 10a. State 10b. County at 10c. City. Town or Location Director ms 23a or 28a-f s must be notified 1 X Yes 2 □ No Maryland Frederick Frederick 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 5326 Sovereign Place 21703 United States items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Examiner Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates. ŏ by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black "natural", 3 Widowed 4 Divorced Completed Medical 16a, Decedent's Usual Occupation Decedent's Education 16b. Kind of Business/Industry المالية. عا Hygiene. عاد **r than "r** (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Community Action Elementary/Secondary (0-12) College (1-4 or 5+ the 3 years Rehabilitation Counselor Group marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Mary Elizabeth Talbott Hunter James Harvey traumatic and I 19a. Informant's Name/Relationship (Type, Print) (Wife) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 Katherine Lorine Outten Hunter 5326 Sovereign Place; Frederick, Maryland 21703 other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Page 1 Department of Important: If it any injury or o 1 🛮 Burial 2 🗆 Cremation 3 🗆 Removal from State Jan.14,2012 4 ☐ Donation 5 ☐ Other (Specify) Glenwood Cemetery Washington, D.C. 22. Name and Address of Facility R. N. Horton Company Morticians, Signature of Funeral Service Inc.;600 Kennedy Street, N.W.; Washington, D.C.2001 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final "hysician/ Probable Acute Myocardial Infarction disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Coronary Artery Disease Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Cause (Disease or injury attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical certificate be Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Pregnant at time of death Day 1 ☐ Yes ∠ ☐ 9 ☐ Unknown the Unknown P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Oxygen-Dependent Chronic Obstructive Pulmonary Disease 1 Tes 2 No 3 Probably 4 Unknown Records, 24b. Were autopsy findings available prior to completion of cause of 24a. Was an funeral director, pege 2 s has autons performed?

Yes 2 X No death? 1 ☐ Yes 2 ☐ No this certificate Division of Vital • Hospital or Attending Physician: 24 hours after death. • Funeral Director: After this certific. 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 **X** No 1 Yes ြု 1 Inpatient 2 XER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: X Natural (Month, Day, Year) 5 Pending 1 Yes 2 No Accident the Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, filled in by determined Medical 🛣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

CR 5

Manuel Casiano, M.D.
Date filed (Month, Day, Year)
JAN 2 3 2012

29b. Signature and title of certif

M.D. 400 West 7th Street; Frederick, Maryland 21701

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 29c License number

DOD 35267

Frederick Memorial Hospital

29d. Date signed (Month, Day, Year)

2012

12-00399 Stephen Horsley

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2012 04000 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day January 14, 2012 Stephen J. Horsley Medical Examiner 0010 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Prince George's Hospital Cheverly Prince George's 5. Social Security Number 7. Age (In yrs, last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or **Funeral** Foreign Wash. DC Director Months Days Hours Min. 579-23-2684 18 2-25-1993 1X M 2 F Country Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits is 23a or 28a-f show ie notified at once. Washington 1 Yes 2 No Pages 1 and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene.

Inter If item 27 is marked other than "natural", or items 23a or 28a-f sho Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1829 I Street, NE #1 20002 USA Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces White etc. 1 X Never Married 2 Married 1 Yes 2 X No Specify: Black 3 Widowed 4 Divorced f Yes, Give Yeer 1 Yes 2 X No specify: Š 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Student Education Itimore, MD 21215-0036 10 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Stephen Edwards Be Crystal Horsley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1829 I St., NE Crystal Horsley #1 Wash., DC 20002 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Glenwood Cemetery 1/23/2012Wash., 21. Signature of Funeral Service License 22. Name and Address of Facility Tyrone J. Young Fun. Eads St. NE Wash., nter the disease. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart mplications at caused the death Approximate Interval **Physician** fail rg. List only one cause Between Onset and /Medical Death a Multiple Gunshot Wounds Immediate Cause (Final disease ≛xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and or use as the burial - transi cian/Medical UNPENDED AMENDED Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Fetal death Month Day Year 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown detached f Records, P.O. After this certificate has been signed by i funeral director, page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 至 1 Yes 2 ✓ No 3 Probably 4 Unknown Completed 24a. Was an 24b, Were autopsy findings available autopsy prior to completion of cause of performed?

✓ Yes 2 No death? 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Division of Vital Be examiner? Hospital: 1 ☐ Inpatient 2 ✔ ER/Outpatient 3 ☐ DOA Other Nursing Home 5 Residence 6 Other 1 ✔ Yes 2 No 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28d. Describe how injury occurred Jan 13, 2012 n 24 hours after uc.....he Funeral Director: A 1 Natural Subject shot 2315 hrs 1 Yes 2 ✔ No Pending 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) 4619 Benning Road SE, Washington, DC determined (Specify) Other (courtyard) 4 V Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Sa 2 [v] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E January 14, 2012 Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 Laron Locke MD. State Registrar

DHMH 17 Rev 1/2001 OCME 2006

OCME